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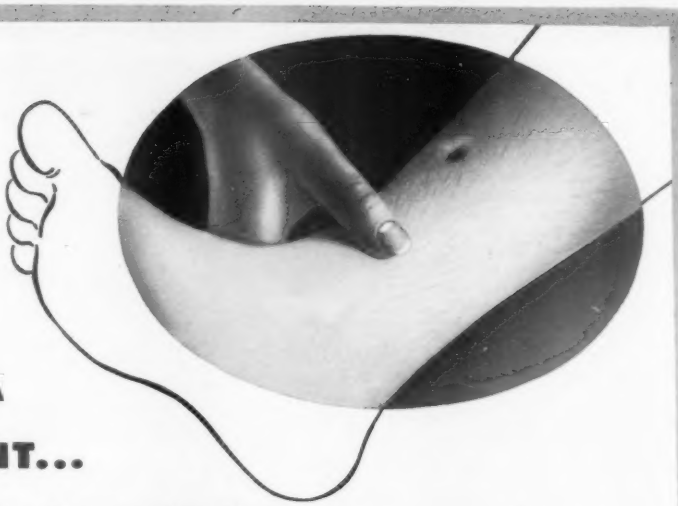

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1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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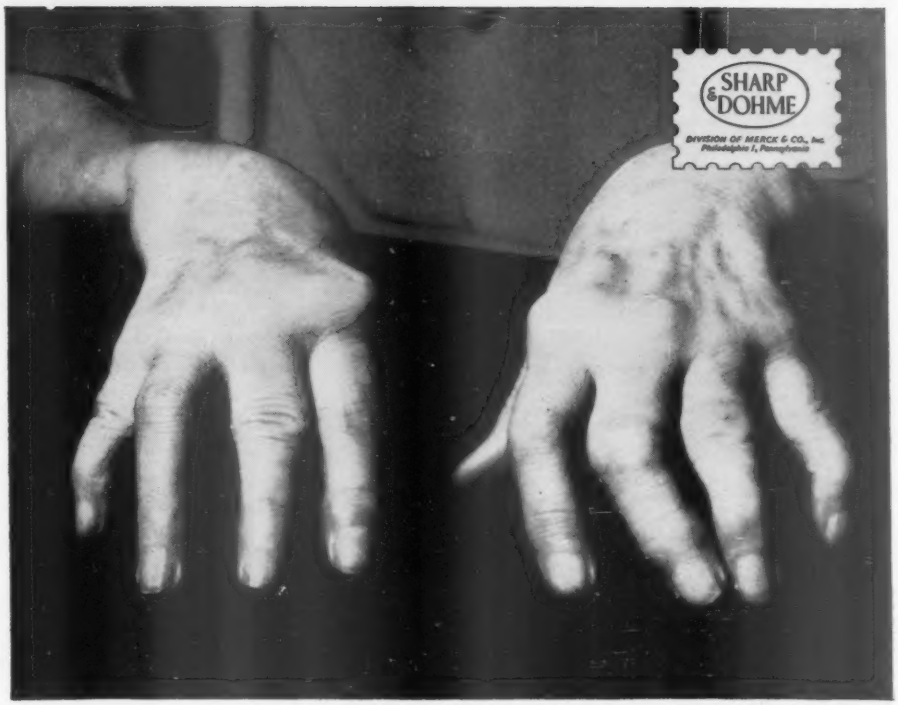

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Rocky Mountain Medical Journal

FEBRUARY, 1954

Colorado - Montana - New Mexico
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Far, Far From Dead!

ANY belief that the issue of socialized medicine is dead surely has been dispelled by President Eisenhower's "middleway" approach to a "national health plan" in his January 18 message to the Congress, and also in view of legislative proposals already actively in the Congressional hopper.*

The President would create a federal corporation with the avowed aim of financially bolstering the voluntary health plans by "reinsurance" so they can "provide more adequate medical and hospital care." In his message he said that while "rejecting the socialization of medicine we can still confidently commit ourselves to certain national health goals." We believe President Eisenhower is a completely sincere man. But the so-called "goals" in his proposals make us fear that he has been sold a bill of goods by that same group of career-socializers whom the new administration has still not managed to weed out of the various federal agencies. We will be very happy if the future proves us wrong, but in preliminary study these proposals look like another wedge prying the door to socialization open a little wider.

This "middleway" sounds to us like going more than halfway toward the last administration's definitely socialistic compulsory scheme. We might almost say, "Hold onto your hats, boys, here we go again!"

While Mr. Eisenhower may feel one way about the matter, there are others who take them is Representative Wolverton (R-N. J.) who has introduced a bill which would, among other things, require insurance plans to guarantee six months' medical care if they are to participate in the reinsurance plan, and would provide coverage for up to a dozen house calls by the physician.

One need not be a Solomon to predict how far certain Congressmen might be willing to go in the matter of federal handouts for hospital and medical care in this year of 1954 which will be marked by elections involving all the Representatives and one-third of the Senators.

Every informed person, we believe, is eager to see our voluntary health insurance programs develop in the public interest. Wonderful progress has been made, and there is no reason to feel that both the commercial and the non-profit plans cannot expand further. But in so doing they, and the physicians, and the public, must recognize that sound actuarial practices are mandatory. No insurance of any kind can properly serve the people if it goes broke by virtue of unsound financial practices.

Just because the "pie in the sky" medical bill might be picked up by Uncle Sam does not make the proposal any more feasible—unless we are willing as an American people to travel farther down the socialist road. In health insurance, as in any other business including the business of government or the business of running our daily lives, we have simply got to learn to shy away from the something-for-nothing philosophy. It has never worked yet.

*See also "Political Health," Page 150.

Denver's Your Host

PHYSICIANS from the Rocky Mountain area will convene in Denver February 16-19 for the Ninteenth Annual Midwinter Postgraduate Clinics, long regarded as one of the finest medical meetings in the West.

The committee has developed a splendid program with eight guest speakers who will provide unusually interesting papers and discussion leadership in accordance with the pattern of the Midwinter Clinics. Headquarters will be at the Shirley-Savoy Hotel and every doctor of medicine is welcome to attend.

The program will offer much of interest to the general practitioner but will also be of great value to the specialist. The customary stag smoker on Tuesday night and the annual dinner dance Thursday evening will highlight the entertainment for the week.

Colorado and Denver are pleased to be host to the nearly 1,000 physicians who attend this meeting each year. The excellent scientific program and the opportunity for renewing friendships make the Midwinter Clinics most attractive to our Rocky Mountain members.

"The Razor's Edge"— or Who's Cutting Whom

THE Wisconsin Medical Journal for last July carried an editorial which has tickled the pens of several fellow editors. Its author had arrived at the barber shop during the rush hour on Saturday. No social solvent, such as alcohol, is necessary to unleash the tongues in barber and beauty shops. We know about barber shops; the women bring home a few pearls from the others. Trade schools might do well to add some lectures on ethics in their curricula.

"Many a truth is said in jest," and a contemporary bard has said that we are what people say we are—behind our backs. Thus, our colleague picked up a few points in the barber shop. More than ever he realized that patients are often a lot wiser than we might suspect; and usually they know more about doctors in general, and the physicians of their choice in particular, than we think. In this instance, some of our faults were aired, and the doctor saw himself as others see us:

Unfortunately too many people think all doctors charge too much. For those who receive unitemized bills "For professional services rendered" which seem unreasonably high, and then see too much evidence of affluence among medical men and their families, their impressions seem to be confirmed. When a layman has tried unsuccessfully to procure medical services at night, he is apt to be embittered. If he waited two or three hours the last time he went to his doctor's office, he resented it. His time is valuable, too.

A few patients figure that some doctors boost the ante when health insurance forms are presented to be filled out. No wonder, in his mind, that premiums have gone up. These things invite socialized medicine. How about "smart-alecky" office girls who ask too many personal questions, and sometimes before other people? But more important, what about the physician who seems to be devoid of sympathy? A smile and some explanation about what's wrong and what is the best thing to do about it might do a lot more good than a shot of penicillin, and it would be a darn sight cheaper! And how much is it going to cost, Doc? "Don't worry about that," he says. Suppose you gotta worry about it? Furthermore, how come so many doctors slam each other? That doesn't sound like much of a man, especially a professional man, and it beats down a fellow's confidence in all of them.

There you have it, men—right straight from the barber shop. What would the barber have said, had he known his next patron was a surgeon? He'd probably have been so nervous that somebody's life would have been in danger. Not only that but it might dawn on the barber that he is a man of great responsibility, standing there with a razor in his hand. Maybe he'd better double the price of a shave, especially if his patron survives!

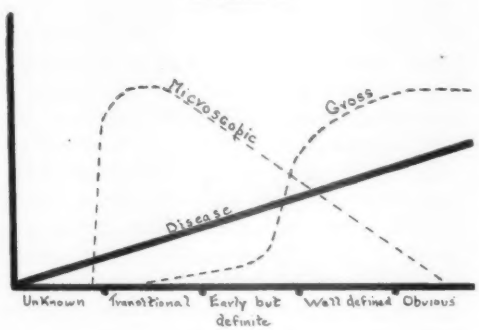
Proper Biopsy Technic*

JOHN H. CARLQUIST, M.D.
Salt Lake City, Utah

PERFORMANCE of a biopsy is such a simple procedure in comparison with gastrectomies, pneumonectomies, anastomoses and other operations that discussion of this subject hardly seems warranted. And yet, because of its apparent simplicity, this subject and its basic principles receive little attention in medical schools or medical literature. We are told when to do them, but not how to do them. Yet a biopsy may be as life-saving to the patient and as important in prognosis as many major operations.

Adherence to basic principles of biopsy is essential in order to gain the maximum information. In tissue diagnosis, we might chart the relative values of gross and microscopic study as correlated to the stage of development of disease.

CHART 1.



In the advanced or obvious stage of disease development, gross examination of the lesion is all that is necessary; microscopic study is only confirmatory. In the well-defined stage, the lesion is generally definite to the naked eye, but microscopic verification becomes increasingly important.

In the early but definite phase, gross examination begins to lose its value. A lesion can be detected visually, yet a differential cannot be established upon this alone. But under the microscope, definite tissue changes are present. It is in this zone, and the following transitional zone, that all principles of biopsy must be followed closely to permit the pathologist to supply maximum information on tissue removed.

The transitional zone is our present major battle-ground with disease. It is at this point that we leave the known and well-established pathways of disease and sail out into the unknown. And yet it is this zone that is important to the patient, for it is at this stage of development that disease can generally be most easily eliminated.

Lastly, there is the unknown zone, where the tissue processes are beginning their early stirrings and rumblings, but they are either too insignificant or we are too insensitive to detect them.

There are four factors that must be considered in every biopsy before the surgeon can receive information on which to base his therapy. These factors are proper biopsy technic, proper fixation, adequate clinical information and the pathologist.

CHART 2.

SATISFACTORY BIOPSY DIAGNOSIS

Proper Surgical Biopsy Technic
+
Proper Fixation and
+
Adequate Clinical Information
+
Pathologist
= Proper Diagnosis

We can consider the last one first. Pathologists, like surgeons, are only human.

*The author is Pathologist, Dr. Groves, L.D.S. Hospital, and Associate Clinical Professor of Pathology, University of Utah School of Medicine, Salt Lake City, Utah.

Paper read at the Regional Meeting of American College of Surgeons, Salt Lake City, Utah, April, 1953.

Much as we would like to be dispassionate, abstract and scientific in our conclusions, our diagnoses are a product of our background, personality and training. And like surgeons, we tend to be conservative or radical; or, being pathologists, we can be better described as "benign" or "malignant." It is not in the well-established lesions that these traits come out, but in the difficult transitional zone, where one man may call a lesion a "carcinoma in situ," while the other will call it "squamous metaplasia." Such a variance in diagnoses is upsetting to the beginner in pathology or surgery, for he has carried away the conviction from his sophomore year of pathology that the pathologist sees all and knows all. But the better rounded surgeon, especially one with training in pathology, will recognize the problem and realize that a dogmatic statement cannot be made. In such borderline cases, it is the responsibility of the pathologist to point out in his report that they are borderline, that he has recognized the difficulty of making a clear-cut diagnosis, given careful thought to the problem, and with all the evidence available, has given his best opinion. In other words, the surgeon should be made well aware of the fact that he is dealing with a transitional lesion, and that the therapy must be compounded from the clinical course, the age of the patient, the site of the lesion and all of the other involved factors.

The biopsy technic, the next factor, is dependent upon the location of the lesion and the purpose of the biopsy, whether it is to be for diagnosis or eradication plus diagnosis. If eradication is desired, the lesion should be removed with as adequate a margin as the location permits. If the purpose of the biopsy is diagnosis, it is most essential to remove marginal tissue to permit demonstration of transitional changes at the margin of a lesion. For example, a biopsy from a center of an amelanotic melanoma may easily be confused with an anaplastic squamous cell carcinoma, while the margin may show the more characteristic cell type to enable the pathologist to arrive at the right diagnosis. The specimen should not be crushed. It is technically simple to grasp a lesion in a clamp when removing it, but this may produce such marked distortion that no diagnosis can be made. Cautery should also be avoided. The desired biopsy should be removed with scalpel or blade, and only after adequate tissue has been removed in a non-distorting fashion, should cautery be used if desired.

Fixation is the next important step. The specimen should be fixed promptly. If, inadvertently, the specimen should be left to dry while the patient is bandaged or instructed, the specimen may be placed in water for a few minutes before fixation. This should, however, be avoided if possible. An adequate amount of fixative should be used, either formalin, Zenker's or Bouin's, dependent upon the individual preference of the pathologist. It is important, if the specimen is large, to make several transverse, non-distorting incisions across it to permit proper penetration of the fixative before central degeneration occurs.

Proper clinical information is extremely important. The name of the patient, sex, and age should be given. It is helpful to know the pre-operative diagnosis. This enables the pathologist to visualize the problem as the surgeon saw it. The duration of the lesion, if known, the rapidity of development, the location and the appearance are valuable. A complete history is absolutely mandatory in gynecologic biopsies for adequate evaluation. A knowledge of the menstrual cycle is important in evaluating hormonal changes.

After our consideration of the basic principles of biopsy, we can consider the more specific sites. Numerically, the commonest biopsy is from the skin. The same general principles apply here, but there are some special points of importance. As always, an adequate history is essential, but this becomes increasingly true in the generalized types of dermatitis. The tissue pattern in the chronic dermatidides varies with the age of the lesion, so a note should be made as to the stage of development.

The gross appearance of lesion becomes altered by excision and fixation, and the pathologist may be unable to form a definite opinion from the gross appearance alone. It is not only in the diagnosis, but in the extent of the lesion, that one may be

fooled. A relatively small skin lesion may extend widely along the derma or deeply into the underlying tissue.

Transitional zones are important in studying skin lesions. It enables the pathologist to compare and more carefully recognize changes that have taken place. Many skin changes are so scanty and poorly defined, that this additional evidence is needed.

Again, in generalized lesions as they age, fibrosis and epithelial atrophy may obliterate important diagnostic features. Also, unfortunately, many skin lesions have no characteristic cell pattern. In this group of entities, the only help that the pathologist can offer is to distinguish them from the more serious forms of skin disease, and he is often forced to fall back on the use of the term "compatible with," rather than using more definitive diagnoses.

In summary of this group, the pathologist shcuild be in a position to make a definite diagnosis in most neoplasms and the serious forms of dermatitis such as lupus erythematosis, mycosis fungoides and lymphomatous skin lesions. And while not giving absolute diagnoses in other forms of skin disease, he can eliminate the more dangerous types in the differential and at least be able to tell the clinician that it is "compatible with" one type or other.

The next commonest sites of biopsy, the endometrium and cervix, while anatomically related, are better considered separately from the standpoint of discussion.

The importance of the endometrial biopsy is emphasized by the indications for such a procedure, and no therapy, whether hormonal, surgical, or irradiation, should be instituted without a knowledge of the endometrial picture. Such a dogmatic statement implies that all is known about the physiology and pathology of the endometrium. Unfortunately, this is not true, but with the tremendous attention that has been given this field in recent years, we can generally stand on fairly firm ground in our interpretations of this tissue. It may be quickly countered that expense of hospitalization, anesthesia, tissue fee, and surgical fee plus delay and inconvenience tend to nullify the value of such a procedure. But in rebuttal, it can be pointed out that the use of costly hormones, incomplete surgical operations, and delays in the therapy of neoplasm more than outbalance these.

What principles underlie a proper endometrial study? First, there should be a proper clinical history with age, menstrual history and indications for biopsy, whether sterility study, menorrhagia or metrorrhagia, suspected ectopic pregnancy, etc. For example, a section may show abnormal proliferative-phase endometrium, but when we are told that it comes from the latter part of the cycle, in what should be the premenstrual period, it becomes quickly apparent that we are dealing with an anovulatory cycle. Second, there is the timing of the biopsy to be considered. A biopsy taken a few days after menstruation in a sterility case is entirely meaningless in attempting to show occurrence of ovulation. I feel that the proper time for endometrial biopsy in sterility cases is at the onset of menstruation. If performed at this time, there is less likelihood of interrupting a desired pregnancy, and secretory changes should be easily demonstrated. Certainly, if secretory activity is not present at this time, it is definitely abnormal. In the concept of incomplete or irregular shedding due to excess progesterone activity, the biopsy must be performed after menstruation is well established to determine the persistence of secretory glands. In that the period is prolonged with this entity, a study on the sixth or seventh day is preferable. In cases of irregular uterine bleeding, proper timing is more difficult to achieve. Curettage may be resorted to after many days of bleeding, using the procedure as both a therapeutic and diagnostic one. It is true that such material may show retained placental tissue, necrotic polyps, hyperplastic endometrium, or other changes as the cause of the bleeding. But as a general rule, the closer the curettage can be performed to the onset of the bleeding episode, the more likely it is true that tissue will be present on which a diagnosis can be based. Later in the period, much or all of it may have sloughed away, leaving insufficient evidence for diagnosis.

As far as the actual technic is concerned, there are only three points of practical importance. A sharp curet should preferably

be used to prevent undue fragmentation and distortion of the tissue. If fragments are obtained that grossly appear different from the other tissue, they should be preserved separately, rather than lumping them all together. And last, the tissue fragments should be washed free of blood before being placed in the fixative. This can be accomplished by passing the gauze containing the material through water two or three times to hemolyze the blood and then gently picking the tissue free from the gauze and placing it in the specimen bottle. Blood tends to cake about the tissue fragments if not removed. This clot fixes and stains poorly, and inadequate tissue studies may be obtained. Such technic also enables the surgeon to see more certainly the amount of tissue that has been removed and determine its adequacy.

There is no biopsy procedure that can be as helpful in diagnosis, as good a guide in proper therapy, or as useful in avoiding unnecessary surgery as a properly performed curettage. On the other hand, I know of no biopsy procedure that is as meaningless or unrevealing as an endometrial biopsy in which proper thought has not been given to the clinical problem faced and the histologic information to be learned.

The subject of cervical pathology should be approached humbly, for the major purpose of cervical study is to determine the presence or absence of carcinoma. Ten years ago, the pathologist could have made as dogmatic statements about the diagnosis of carcinoma of cervix as the gynecologist could have made about therapy. We assumed that these matters were more clear-cut and unequivocable than in any other tumor field. But today, we are in the stage of both diagnostic and therapeutic flux, and many of our earlier concepts are disputed or have been proved more or less valueless. Changing concepts in this field, plus the added interest which it has received, stem from the studies of Dr. (G. N.) Papanicolaou. The finding of apparently neoplastic cells in cervical smears leads to closer cervical studies and this, in turn, leads to the demonstration of non-invasive cervical carcinomas or the so-called "carcinoma in situ." Such lesions have been reported in the past, but never in the numbers reported in recent years. This concept has not gone unchallenged. It is true that most pathologists feel that there is a stage in the evolution of a malignancy when it is still localized, a "carcinoma in situ" if you wish. But a conservative group has risen to oppose the reported frequency of such a lesion, although recognizing that it does occur. A central clearing registry has been proposed by one faction in an attempt to gain reliable and authoritative information on this point as well as to prevent needless therapy. In the face of such variable opinion, what can we rely upon in our study of cervical lesions as to proper technic and reasonable working diagnoses? First, we can say that the well-established malignancy offers no special problems as to biopsy or diagnosis. The biopsy should be taken from the site of definite involvement. The same principle holds true in studying other obvious lesions of the cervix.

It is in the essentially innocent-looking cervix that the surgeon is placed in a quandary as to where and how to perform a biopsy when clinical symptoms warrant it. Various technics have been developed in dealing with this problem, many of them consisting of superficial conization of the cervix. A rational approach to this problem was brought out in a survey of early carcinomata reported by Foote and Stewart in Cancer.* In a series of early tumors, they pointed out that if the biopsy was taken from the central junctional area of either anterior or posterior lip, 47 per cent of these early lesions would have been discovered. If both lips were biopsied, the positives would climb to 74 per cent. If, in addition, material was taken from the lateral angles of the cervix, 93 per cent would presumably have been reported as positive. Such a plan does lend itself to practical study in this problem. Short of a complete conization, it does give wide sampling of the areas, the junctional ones, where malignancy is most apt to appear. Very adequate fragments of tissue can be obtained by a cervical biopsy forceps. The remaining 7 per cent were within the canal and cervical curettage might have revealed them.

*Cancer, 1948, Vol. 1, No. 3.

There are other factors that may be placed in consideration. The women with "carcinoma in situ" generally fall into a younger age-group than those with obvious malignancy. This is important because an accurate diagnosis should be established so as not to interfere with their child-bearing period. Secondly, it has been pointed out by most authors that there is a long latent period before full-blown carcinoma appears on the heels of a "carcinoma in situ." Because of these facts, two principles should be followed in biopsy. First, if the four-quadrant scheme is followed, each fragment should be identified separately. This aids in isolating the suspicious quadrant so that further biopsies can be removed for study. Secondly, because there is no urgency, ample studies should be made to enable the pathologist and clinician to arrive at as definite a conclusion as possible before instituting extensive surgical therapy.

In summary, it can be said that while the subject of cervical carcinoma is still in a state of flux and discussion, because of the ready accessibility of the cervix for biopsy, earlier diagnoses should be made. As far as smear studies are concerned, there is no question that smears from the cervical canal will yield more positive results than those from the vaginal vault. It should also be stressed that early carcinoma of the cervix ("carcinoma in situ") does not shed or exfoliate cells freely as does the well-established carcinoma and, therefore, the study of smears is not a reliable method of diagnosis. While there is no question about the value of smear studies, as the matter now stands in the country as a whole, the major dependence for diagnosis of the cervix must still rest on cervical biopsies.

Lymph node biopsies have some special features that we should point out. The diagnosis of a malignant lymphoma is frequently fraught with difficulty due to the fact that in the early stages a deeper node will often show the more typical changes, whereas the superficial, less involved nodes may have changes difficult to recognize. Frequently, in studying lymph nodes, instead of the lymphoma that one expected, one will find granulomatous lymphadenitis. A specific diagnosis may be made, but often, one can only say that it is granulomatous without being able to name the causative organism. For this reason it is a good practice to preserve a segment of the node for culture. This will often lead to a definite diagnosis in cases that would otherwise prove baffling and inconclusive.

Another important point in lymph node biopsy is to avoid crushing the node; and it also is often helpful to remove the node with a thin layer of adipose tissue about it. The diagnosis of a malignant lymphoma often rests on tenuous evidence. The persistence or absence of normal architecture and slight cellular changes are part of the criteria we use. In a badly crushed, poorly fixed or fragmented node, we lose our major guides. Invasion of the capsule is still another index of malignancy. The presence of a small amount of attached adipose tissue better enables us to evaluate this.

Lastly, in consideration of special sites of biopsy, we should mention rectal biopsies. The potential malignancy of rectal polypi, or polypoid rectal adenomata, as they are better called, is well recognized. It is also well recognized that these polypoid tumors will show all variations of atypical cell growth from earliest cell irregularity to full-fledged malignancy. The therapy is dependent to some extent upon the degree of cellular change, but more upon evidence of basilar extension or involvement. In order to give adequate evaluation of this lesion, the tumor should be removed intact with preservation of the stalk. If this is impossible, basilar fragments should be kept separate to aid in this evaluation. On such technics, proper therapy or proper conservative follow-up can be instituted. The same general principles of biopsy technic can be applied to tissue removed from any body site, other than those previously described.

In summary, one can say that biopsies are valuable diagnostic aids to the surgeon. Their accuracy and diagnostic value can be increased by recognizing the simple principles involved, as well as the limitations. They still represent the simplest and best approach to the verification of a tumor diagnosis, and if properly utilized,

History of Rabies in Colorado

GEORGE W. STILES, M.D.
Denver

WHILE rabies was one of the oldest known diseases of animals, having been recognized more than three thousand years ago, it still creates serious public health problems in areas where the malady becomes epizootic.

World Distribution of the Disease

Prior to the 18th Century, rabies was primarily a disease of wild animals, and dogs were not an important factor in harboring or spreading the disease. The first recorded outbreak of rabies among dogs occurred in Italy during 1708. A few years later the disease spread to major cities in Hungary, Germany and France. In England, rabies was recognized among dogs in 1613, but it did not assume epizootic proportions until 1734.

Now rabies is common in Russia, Spain, Africa, Japan and China, but is of lesser importance in some of the other European and Asiatic countries. Due to effective quarantine measures, rabies has seldom gained a foothold in England, Holland or Switzerland in recent decades. Australia and Hawaii are reported entirely free of it, both among wild animals and dogs.

According to H. N. Johnson, Annals of the New York Academy of Science, April 10, 1947, there is no evidence that rabies existed in either South or North America prior to colonization. Now it is common in Mexico and parts of South America. Historical archives of the State of Virginia indicate that rabies was prevalent in 1753, in North Carolina in 1762, and among dogs throughout New England during the years 1770-1785, and by 1860 the disease had invaded most of the states east of the Mississippi River. California appears to have been free of rabies until 1899.

The ravages of a mad wolf recorded in original historical papers were retold by Bernard De Voto in his well documented book, "Across the Wide Missouri," published in 1947, a beautifully illustrated account of the life and customs of trappers and fur traders of the western plains and mountains. The narrative shows that in July of 1833 a gaunt, rabid wolf, with haggard eyes and hanging jaws, made a nocturnal visit or two to the camp of a party of Rocky Mountain Fur Company men and other travelers at a trading rendezvous on the upper waters of the Green River, west of Fort Laramie in the present State of Wyoming.

Three men were bitten at the Rocky Mountain Fur Company camp and nine others at a nearby camp of the American Fur Company; at least one Indian was a victim. A bull also was bitten at the Rocky Mountain Fur Company camp, and its bellowing added to the noise and confusion occasioned by the mad wolf. The bull later died while the party was on the way to the Yellowstone River. Several of the attack victims developed rabies and died in paroxysms before the camps broke up, and a number were stricken on the trail and wandered off into the mountains to die. During the following two years, several otherwise inexplicable deaths that occurred among the men of the mountains were attributed to the rabies outbreak.

The historical documents used by De Voto also revealed that one of the Rocky Mountain Fur Company victims named George Holmes was badly bitten on the right ear and face. According to the memoirs of another member of the party, Holmes developed a phobia of crossing streams and was covered with a blanket in order to get him across. After some time, the sick man was left in the custody of two men from another party but was abandoned. Later, search-

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parties were able to find only his clothes. A victim of hydrophobia, he had wandered away naked and never was found.

Another member of the Rocky Mountain Fur Company party wrote a different version of Holmes' death, which De Voto also presented. This version is that Holmes became a changed and ailing man after being bitten by the mad wolf. In November of 1833, melancholy and wasted, he set out with a physician who had accompanied the party and with a third man to search for a stone, or talisman, believed to be a cure for the madness. Holmes perished, however, and it was said that his bones were left on the bank of some stream, the exact spot unknown.

The above described outbreak of rabies in animal life and man appears to be the earliest recorded episode of the disease in the Rocky Mountain area.

A second mad wolf incident was reported by Rufus B. Sage in a book about his travels in the early 1840's, "Rocky Mountain Life; or Startling Scenes and Perilous Adventures in the Far West," published in 1846. In the diary of events on October 18, 1841, he narrated that a furious mad wolf, the largest of its species, appeared at night at an encampment on the Platte River near Chimney Rock in Western Nebraska. The animal, with blood-red eyes and foaming mouth, bit nine head of horses and cattle. In addition, the strange department of a buffalo bull was observed on the plains. Running in circles, frothing at the mouth, with protruding swollen tongue and rolling eyeballs, the bellowing, half stumbling animal finally fell prostrate in the last paroxysm of pain. A friendly bullet ended his excruciating suffering from the horrors of hydrophobia.

Various names of Indian chiefs that indicate recognition of the rabies prevailing in the West prior to 1847 appear in the historical accounts collected and edited by Reuben Gold Thwaites in the volume, "Early Western Travels, 1738-1846," published in 1907. The names include Crazy Bear, Crazy Horse, Crazy Snake, Mad Dog and Mad King.*

*Acknowledgements are made to Dr. LeRoy R. Hafen, Colorado State Historian, for his kindly assistance in supplying this information.

Recorded Rabies in Colorado

Official records show that rabies has smoldered in Colorado for more than fifty years.

Recorded Cases 1898 to 1939: During his practice in Denver, Dr. Edwin R. Axtell reported in the Colorado Medical Journal, November, 1899, a clinical case of "hydrophobia" in an eight-year-old boy who was severely bitten through the upper lip by a stray dog on November 2, 1898. The wound healed in a few days, but typical symptoms of rabies developed after twenty-three days of incubation. The case was observed by Drs. Jeremiah T. Eskridge, Henry Sewall and William C. Mitchell, who concurred in the diagnosis. The child died in great fear and agony after about five days of illness. As Negri bodies—the presence of which indicates rabies in laboratory tests—were not discovered until 1903, laboratory confirmation was not obtained.

According to the "Fifth Report" of the Colorado State Board of Health, November 15, 1894, to November 15, 1900, two fatal human cases of rabies were reported in 1900. At the meeting of the Executive Committee on February 24, 1900, it was reported that an outbreak of hydrophobia among animals had developed in Douglas County, and that the State Board had been requested to investigate. Interestingly enough, although the Board desired to do this, it was deemed impossible "because of lack of funds." One death from human rabies in 1902 was reported in the "Sixth Report" of the Colorado State Board of Health, November 15, 1900, to November 30, 1902. In an editorial in The Medical Times and the Utah Medical Journal under date of February, 1910, Dr. A. R. Peebles discussed the problem of rabies in Colorado. He cited positive laboratory diagnoses of thirty-five dogs during the year and commented upon the possible existence of the malady in various areas of the state.

The minutes of the regular meeting of the State Board of Health, held on January 30, 1918, show that on a single occasion in 1917 a total of nine persons were exposed to rabies. A very interesting account of this incident was told to the author recently by

Dr. Sherman Williams, who was president of the State Board of Health in 1917, and by Miss Olive L. Baker, formerly Doctor Williams' assistant. Doctor Williams said, "Nine persons were bitten by a stray dog on the train between Denver and Longmont." The doctor prepared rabies and vaccine and began injections, giving each of the nine victims three doses the first day, two the second day, and one daily thereafter until a total of twenty-five doses had been administered to each victim.

During the rabies season of 1918, Doctor Williams administered three initial injections of vaccine to as many as thirteen persons on a single day, making thirty-nine initial injections a day. An additional difficulty was that the dried spinal cords of rabbits that were used in preparing the vaccine were expensive and scarce. Both Doctor Williams and Miss Baker recalled the death of one woman who expired before vaccine prophylaxis was given. They said that none of the patients who received vaccine developed the disease.

Dr. Edward R. Mugrage of the University of Colorado School of Medicine related his experience with rabies, beginning in 1918, in a personal communication to the author dated August 1, 1950. Doctor Mugrage's first case, in 1918, was that of a puppy owned by his laboratory helper. The diagnosis was confirmed by Drs. Ross Whitman and Sherman Williams. Doctor Mugrage referred to a definite epizootic in 1927 in West Denver and adjacent sections toward the mountains. During the year over 100 positive cases in animals were diagnosed, including that of a brindle bulldog which ranged between Aurora and Englewood. The dog was known to have bitten fully sixty head of dairy cattle, and one herd of twenty cows was virtually exterminated. During this outbreak Doctor Mugrage made many photographs, including a fine set of animal movies. His observations were published in three articles in the Colorado Medical Journal, June, 1929, and April, 1929, also Journal of Laboratory and Clinical Medicine, February, 1930.

From 1922 to 1939, Dr. William C. Mitchell, State Bacteriologist and Director of the Laboratory, showed in the reports of the State Board of Health approximately 350 examinations for rabies, unclassified as to animal species and laboratory test results. Records compiled by the author, at the Branch Pathological Laboratory of the

NUMBER OF REPORTED POSITIVE CASES OF ANIMAL RABIES

Year	Dogs	Cattle	Goats	Cats	Total in Colo.	Total in U. S.
1940	8	0	0	0	8	7,238
1941	59	8	2	0	69	7,877
1942	34	6	0	2	42	7,165
1943	6	3	0	2	11	9,690
1944	1	0	0	0	1	10,540
1945	4	0	0	0	4	9,963
1946	5	0	0	2	7	10,872
1947	13	0	0	0	13	8,946
1948	1	0	0	0	1	8,508
1949	19	0	0	2	21	7,597
1950	106	4	0	9	120*	7,910
1951	3	0	0	2	5	8,022
1952	1	0	0	0	0	8,499†

*Includes one skunk.

†Classified according to animal species, the 8,499 cases reported in the United States for 1952 were as follows:

Dogs	5,266	Swine	31
Cattle	919	Cats	501
Horses	38	Goats	7
Sheep	19	Man	21

Various miscellaneous species 1,697

The reports for the individual states show that in 1952 the largest number of cases occurred in the following states:

Texas	1,411	Kentucky	399
Tennessee	546	Illinois	384
Alabama	535	New York	338
Virginia	476	Mississippi	307
Georgia	436	Pennsylvania	303

Twelve states reported no cases of rabies for 1952.

United States Bureau of Animal Industry in Denver, showed fifteen positive cases of rabies in dogs and one in a cat in Colorado, from 1921 through 1928.

Colorado State Department of Public Health and National Office of Vital Statistics records for Colorado show only five deaths from rabies in humans since 1922. A school boy of 14 years died July 9, 1923, in Las Animas County. The second death was that of a 60-year-old man on October 13, 1924, at Trinidad, Las Animas County. The third victim was a three-year-old boy who died July 26, 1924, also at Trinidad. The next fatality was that of a five-year-old boy who was bitten by a stray dog and died at Windsor on May 15, 1929. The last fatal case, a 62-year-old woman, received thirty-one lacerations on the hand by a rabid dog and died August 19, 1931, thirty days after the bite.

Since 1934, the Bureau of the Census Special Report on Colorado, Summary of Vital Statistics 1944, reports no human deaths from rabies for the ten-year period in Colorado.

The following statistics on animal rabies in Colorado and in the United States since 1940 are based upon official records of the United States Bureau of Animal Industry:

Beginning in July of 1949, but reaching its height in March of 1950, an epizootic of rabies occurred in the City and County of Denver and the three surrounding counties. In February and March, 1950, the peak months of the outbreak, 31 and 32 positive cases were reported, respectively. A total of 120 positive cases—113 dogs, six cats, and one cow—were diagnosed before the prevalence tapered out completely in September, 1950.

The outbreak probably started with the importation of an infected dog from another state. When the epizootic began to assume serious proportions in 1950 it was brought under control by the combined efforts of Federal, State, County, and City health officials and by the splendid cooperation of the practicing veterinarians and the various community organizations. Approximately 70 per cent of the dogs in the four counties were vaccinated during an intensive campaign in March, 1950. Annual vaccination of dogs became mandatory in the co-extensive City and County of Denver under municipal statute, and voluntary annual vaccination was urged by officials in the other three counties in the epizootic area. A regulation adopted by the State Board of Health in April, 1950, prohibits importation into the state of dogs with any infectious or communicable disease, dogs unimmunized against rabies, and dogs from areas in which rabies has existed within twelve months.

Forewarned by the emergency in the Denver area in 1950, numerous other communities conducted special immunization programs and strengthened routine rabies control measures. As shown by the statistics in the preceding section, five positive cases of animal rabies were reported in Colorado in 1951, and only one case on January 7 in 1952, in one unvaccinated dog. None have been reported in 1953 to date of writing, April 1.

A.M.A. Studies Physician Attitudes on Insurance

While there is no doubt that most physicians favor the many forms of voluntary health insurance now in existence over any compulsory tax system, no attempt has been made to analyze attitudes of physicians regarding certain aspects of the voluntary type of protection. The A.M.A.'s Council on Medical Service—through its Committee on Prepayment Medical and Hospital Service—currently is sponsoring a survey of these underlying doctor attitudes.

Since voluntary insurance programs are insuring an increasing number of persons each year, the attitudes of physicians—as they are the ones who render professional treatment to policyholders—are important factors to consider in the future plans of insurance programs.

Among other things, the A.M.A. survey is designed to bring to light certain physician attitudes regarding service benefits, the extent to which the principle of coinsurance should apply, the adequacy of benefits (fee schedules), the extent to which insurance may influence the cost of health care, and so forth.

Although the Council on Medical Service is sponsoring this study, the questionnaire itself was compiled after consultations with the Bureau of Medical Economic Research, representatives from Blue Shield and other organizations.

Facial Fractures . . . Diagnosis and Treatment*

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THE diagnosis and treatment of facial fractures is similar to that of other bones of the body, as once a diagnosis is made and the displacement is reduced, the involved bones are immobilized until they are healed. They vary materially, however, in that many of the fractures involve and alter the function of breathing and eating. The facial bones surround the sinuses which are connected to the nasal airways and are complex in their anatomical structure. When there is sufficient displacement to create a tear in the lining mucosa, blood can find its way through into the nose and, secondarily, into the hypopharynx and larynx so that in the first-aid treatment in some of these cases it is imperative to create an adequate airway free of blood in order to maintain life. Once the individual has been treated for shock and is out of danger from asphyxiation from blood or mechanical obstruction, one then has ample time to carefully study and evaluate the fractures and their treatment.

Gross displacement of fractures is obvious. There are others which are sometimes difficult to evaluate so that any case which has received a severe blow to the face should undergo a routine examination. Examination should first be a visual one comparing the two sides for symmetry. Swelling will frequently obscure a depressed fracture or be so great that palpation through it is impossible. When this occurs, it may be necessary to wait two or three days to permit this excessive swelling to subside before our final evaluation and any reduction is possible. Assuming that there is not excessive swelling, one feels of the nose looking for motion or crepitation. Examining the inside of the nasal cavity, always look for a swelling of the septum which would indicate a fracture of it and hematoma formation. Telltale evidence of a fracture or severe blow is a laceration of the mucosa corresponding to the pyriform aperture. Next, examine the eyes. See if there is any diplopia or limitation of motion. Either of these would suggest change in the orbital contents due to bone displacement. By gentle pressure, both of the orbital rims may be palpated simultaneously. One may start at the inner canthus and palpate both rims symmetrically. The common site of irregularity is at the junction of the zygoma and the superior maxillae along the infra-orbital rim. The next most common location is where the zygoma attaches to the frontal bone. Feeling a step in such a position, diagnosis of a fracture is positive. In such a case, anesthesia of the distribution of the infra-orbital nerve is present as these fractures are prone to involve the infra-orbital canal and either crush or sever the nerve. The patient is then requested to open the mouth and while so doing, we look for limitation of motion or irregularity of motion. Whenever the zygoma is pushed backwards, it impinges upon the coronoid process of the mandible, resulting in a limitation of its motion. One should now examine the bite carefully and if a patient is conscious, he can usually inform you if it feels normal or not. If not conscious, close the jaw and see if the teeth approximate as they should. If they do not, you are sure of a fracture; if they do, you may still have a fracture that is in position. Secure a firm hold of the superior maxilla by placing one's thumb within the mouth against the palate and grasp the upper alveolus with the fingers, immobilizing the head with the free hand. If considerable pressure is exerted on the maxilla, motion may be felt or seen. If there is much dis-

*Presented before the Utah State Medical Association, September 4-6, 1952. From the Massachusetts Eye and Ear Infirmary.

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1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
4. Wolman, B., et al.: Brit. M. J. *1*:419 (Feb. 23) 1952.
5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. *2*:6 (Jan.) 1951.
6. King, E. Q., et al.: J. A. M. A. *143*:1 (May 6) 1950.

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placement of the superior maxilla, it is prone to be down and backwards or with some rotation. This causes the molar teeth, when present, to hit prematurely and results in an open bite. One frequently can determine quite accurately the site of fractures and degree of displacement by physical examination alone.

We should have the best x-rays possible and one is fortunate indeed to have a good roentgenologist assist him. The two x-ray positions that probably help the most in demonstrating facial fractures are: 1. The Water's position in which the chin with open mouth is in contact with the film. 2. The lateral view. The former shows very readily the nasal arch, zygoma, zygomatic arch and ascending process fractures. The latter will show nasal, ascending process, certain alveolar fractures and particularly posterior displacement. It does not help out much on the zygomatic fractures.

Where these fractures communicate with the air passages, patients should be warned not to blow the nose. When they do so, air and contaminated secretions are blown through the fracture lines into the facial tissues and complicate the problem of reduction and healing materially.

Let us now consider the reduction and fixation of the various fractures. The majority of nasal fractures, except in children, may be reduced under local anesthesia, using topical anesthesia within the nose and infiltration of procaine or its equivalent subcutaneously over the bones. Most nasal fractures are of its lower one-half where the bone is thin. They frequently include the thin portion of the ascending process of the superior maxilla. Fractures of the upper one-half are less frequent due to the fact that the bone is thick and quite solid. Rarely are the nasal bones disarticulated in their upper third because they are held firmly in a facet created by the frontal bone and the ascending processes of the superior maxilla. To have a fracture there, one must have a crushing blow which separates the ascending processes and permits the bone to be pushed in or to be knocked out laterally. A depressed fracture in this area should always make one rule out cerebrospinal rhinorrhea as the fracture is prone to go through and involve the perpendicular plate of the ethmoid in the region of the cribriform plate. If we do have cerebrospinal rhinorrhea, it is not a contraindication to reduction. Instead, reduction should be carried out as soon as the patient is able to stand the procedure and have the bones immobilized. Immobilization permits this leak to be sealed off at as early a time as possible, thus preventing secondary infection of the meninges by invasion. Most simple nasal fractures may be reduced by an elevator placed in the nose, followed by external pressure and manipulation. In some of the crushing blows, it is necessary to use a forceps which will grasp fragments of bone which may then be manipulated into position. Most simple fractures may need nothing more than an adhesive splint or an external dental composition splint. Those which have lost the support of the septum may require the aid of a fixation splint introduced within the nose and supported by a head cap.

A common mistake in attempting to reduce nasal fractures is to place the elevator too high within the nose so that it either rests upon the unbroken nasal bones or beneath the nasal spine which is a part of the frontal bone. Care should always be taken, therefore, to place the elevator beneath the displaced fragments only.

The zygoma is roughly a flat bone with three main articulations and four main projections. The articulations are with the frontal bone, the superior maxilla and the zygomatic arch of the temporal bone. The largest and firmest articulation is with the superior maxilla. This articulation if separated will occasionally involve the maxillary antrum. The bone itself is rarely fractured though it, as a whole, is frequently displaced in direction of force of the blow and is either backwards, inwards, or a combination of the two plus an upward or downward motion. The posterior surface is in close contact with the coronoid process of the mandible so that backward displacement impinges upon it and limits motion of this bone. The outer third of the orbit is formed by the zygoma so that displacement downward, inward or upward will cause a change in the volume of the orbit which

may create diplopia. By examination and x-rays, the displacement of the zygomatic bone can usually be accurately determined and its reduction depends somewhat upon the manner in which it has been rotated. There are four main fundamental methods of reduction of this bone and the method should be employed which best fits the case. When the zygomatic arch has been fractured inward and the zygoma has been rotated posteriorly toward the temporal fossa, it is best reduced by employing the temporal approach of Gillies. This consists of making an incision parallel to the temporal artery within the hairline anterior to the level of the upper part of the helix. The temporal fascia is then exposed, incised and beneath this fascia a blunt tipped elevator may be inserted where it will be carried beneath the temporal arch. Once the instrument is in position, the bones may be readily sprung back into position. Considerable force is frequently necessary and a folded gauze pad may be placed beneath the handle as a leverage point. The same approach may be used to elevate rotated fractures of the zygoma proper.

The second method of reducing zygomatic fractures is via the mouth. An incision is made through the mucosa just above the last molar tooth. A blunt elevator is then inserted through the muscle and by feel may be carried adjacent to the bone up in back of the displaced zygoma which may then be elevated laterally or anteriorly. When the bone has been hit primarily on its front aspect so that it is shoved backwards and into or downward into the maxillary antrum, the intra-nasal approach is best. To enter the antrum, a large intranasal window is made beneath the inferior turbinate and through this window a special blunt hook may be inserted, care being taken that the tip is placed behind the displaced zygoma and not in front of it where it will come out into the soft tissues of the cheek. Once it is in position and we are sure it is beneath the solid part of the zygoma, pressure may then be exerted anteriorly, laterally or up or down as the case may require. With the other hand on the outside, bimanual manipulation may be carried out. There are other methods that are available such as a large, double-hooked towel clip or the method of making a nick into the skin and introducing a corkscrew into the bone through which the bone may be manipulated.

The majority of zygomatic fractures do not require fixation because once they are brought back into position they remain there by continuity of support of surrounding soft tissue. There is little muscle pull on the bone to displace them even though we have a fair muscle attachment. When the zygoma is comminuted or when other bones of the face are broken, it then becomes necessary to use fixation until union is obtained. If there is wide separation of the zygoma from the frontal bone, it is frequently necessary to expose the area by an incision through the overlying skin and place two drill holes, one in the frontal bone and the other in the zygoma, and wire directly with stainless steel wire. This may be all that is necessary though not infrequently we need to offer an anterior and lateral pull to prevent collapse of the infra-orbital rim and front face of the antrum. This may be secured by exposing the infra-orbital rim directly or by a Caldwell-Luc approach through the mouth through which a wire attachment may be made, bringing the ends out through the skin where the wire may then be attached to a headcap for support. If there is marked comminution and many fragments of the zygoma, superior maxilla and floor of the orbit are present, it is occasionally advisable to expose the antrum as for a Caldwell-Luc; make a large window into the nose beneath the inferior turbinate and pack the antrum with Penrose tubing for support. The free end is brought out through the nose where it may be removed after a week or ten days with no difficulty.

The superior maxilla is attached to the skull through a series of buttresses, the main ones being the ascending process of the superior maxilla, the lateral posterior wall of the maxillary antrum and the palate bone. All degrees of fractures of the superior maxilla are encountered from a crack through one or two of these buttresses to a complete severence of them all with a freely movable maxilla. Reduction of these fractures may be comparatively easy or on

the other hand, extremely difficult. The problem occurs in adequate immobilization. It is always necessary that the zygoma be in position prior to reducing the superior maxilla and it may be necessary to reduce and fix them by direct wiring first. If teeth are present, a large part of the problem is solved as they are a means of applying traction and fixation but more than that, they are a guide as to alignment that the maxilla shall take. If the mandible is also fractured and displaced, it is imperative that this be reduced and fixed first as it is the main guide that we use. If the patient is edentulous but his dentures are not broken, they may be utilized to direct the replacement of the fractures and also employed in splinting. If there are no teeth or dentures, other means of fixation are required.

Let us assume that the diagnosis, extent of fracture, and displacement have been made and that the individual has teeth remaining which are solid. When the fractures are not impacted, it is usually comparatively easy to manipulate the superior maxilla so that the upper teeth will mesh properly with the lower. This being the case, our problem is one of splinting and a good method is that of applying wires to both upper and lower teeth in such a manner that the teeth may be held together by either elastic traction or wiring. This holds the superior maxilla in the proper anterior posterior position, upward support being all that is necessary to obtain proper positioning. Upward support may be applied by a sling beneath the chin attached to a head cap or by means of a modification of the Kingsley splint which is a framework which is attached to the upper teeth with arms that come out through the mouth and swing laterally over the cheeks to which elastic traction may be applied. In employing this support, it is imperative to be sure that the maxilla meets with resistance of fixed bones of the upper face as we encounter cases where there is much crushing and comminution of the bones in which no resistence is encountered and the mid-portion of the face may be collapsed materially. The chin sling is satisfactory for early support or one that may be of short duration. The Kingsley splint type is more comfortable and practical when immobilization must be carried over several weeks. Kirshner wires inserted through the facial bones from side to side and then in turn fixed up to a head cap, have their advocates and in a few hands are safe in their application. On the whole, they are more difficult to use and are not as safe as the method described. In an edentulous person, a Kingsley splint may be applied to the denture and if the traction is upwards and even upwards and anteriorly, good traction may be exerted through it. There is yet another way of fixation, that which places a wire around the teeth which is then carried just over the front face of the antrum and out through the skin over the cheek where it, in turn, is attached to a head cap.

Simple alveolar fractures are usually fairly readily replaced and immobilized by interdental wiring. Whenever an impacted fracture of the maxilla is encountered, it may be necessary to employ constant traction which will gradually overcome the impaction and permit reduction and alignment. The traction must be applied in such a way that the bones will be pulled in the opposite direction from which they were impacted. This can usually be done by applying wires to the teeth in such a manner that they will form a "button" to which elastics may be attached for traction. If we have a rotation of the superior maxilla downward and backwards, it may be necessary to pull it forward and rotate the teeth downward. This traction may be obtained by applying buttons on the upper molar teeth posteriorly and to the incisors above and below. Elastics joining these buttons will have a constant pull on the maxilla which would tend to pull it forward and rotate it into position. Care must be taken not to apply too much traction to the incisors for fear they may be loosened in their sockets. Once the fragments are freed up and pulled into position, they must then be immobilized and this is accomplished by applying a Kingsley splint to the upper teeth so that upward traction may be applied to a head cap. The fragment is kept in alignment by either wires or elastics joining the upper and lower teeth. Another method of accomplishing the same thing is to apply

a sling beneath the mandible which will be attached to a head cap. This is usually not as comfortable as the former method.

Whatever method is used, one must be fully cognizant of dangers and complications possible and how to avoid them. Occasionally, facial bones are so comminuted that it is impossible to return them to their former contour and it may be necessary at a later date to employ a bone or cartilage graft to restore lost contour or to hold up the floor of the orbit to overcome diplopia.

In this abridged presentation of treatment of facial fractures I hope a few points have been given which will be useful. Remember that reduction is not an emergency and that study can be given each case. Fixation should be effective, using the simplest method available. Avoid methods which are complicated and create secondary scarring and possible complications.

Multiple Carcinoma Of the Colon

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THE following case report is of interest because of the unusual number of carcinomas which occurred simultaneously in the colon and the possible etiologic factor in their occurrence.

CASE REPORT

This 50-year-old white female was first seen on July 20, 1950, with complaints referable to an acute Bartholin's abscess. On routine rectal examination, a hard irregular annular lesion was palpated extending up 3 cms. from the terminal mucosa. Biopsy proved this to be an adenocarcinoma grade II. Subsequent sigmoidoscopic examination above the lesion was not remarkable. The mucosa was slightly injected and redundant and a small sessile polyp was discovered 10 cms. from the anal margin. Follow up barium enema x-ray studies revealed a rather atonic elongated colon with some loss of normal haustral markings and with reduplication and kinking. No definite findings of polyposis or ulcerative colitis were seen. The roentgenological diagnosis was "carcinoma of the rectum with changes suggestive of a long-standing spastic colitis." A warm stool examination disclosed a marked infestation with Trichomonas hominis but no amebae or cysts were found.

The patient's past history was of interest. Her health had been good up to 1935 (15 years) when she was seized with an attack of acute dysentery so severe that bedrest was required for one year despite usual measures to control the diarrhea. She then recovered sufficiently to become ambulatory but the diarrhea persisted with three to four loose stools daily interspersed with bouts of acute dysentery. This condition maintained up to the date of the discovery of her carcinoma. At one time her colitis was diagnosed as amebic dysentery but treatment directed to this was of no avail.

In 1932 an appendectomy was done for a ruptured appendix and in 1946 a left nephrectomy was performed for an "impacted stone in the uretero-pelvic junction with non-functioning kidney."

On August 4, 1950, after the usual preparation for colonic surgery, including the use of amebacidal agents for the control of the trichomonas infestation, a combined abdomino-perineal resection of the recto-sigmoid was done with wide resection of the anal area and including the posterior wall of the vagina. Palpation and inspection of the colon above the site of resection revealed only a rather large, redundant bowel; nothing suggestive of additional malignant changes or polyposis of the bowel was found and no distant intra-abdominal metestases were seen.

Pathologic examination of the removed specimen was reported as "adenocarcinoma, grade II, rectum. Hyperplastic lymphadenitis, regional; chronic sigmoid colitis, non-specific."

Her convalescence was uneventful and complete recovery was made with gain in weight and improvement in her blood picture. Considerable difficulty was experienced, however, with the control of her colostomy; she continued to have bouts of diarrhea and loose stools. Repeated stool examinations during the attacks of diarrhea consistently revealed swarms of Trichomonas hominis but no amebae and despite the use of every known parasiticidal drug, the trichomonas infestation was never completely irradicated.

Three months after her operation, she had an attack of renal colic. Urologic examination revealed extensive pelvic and ureteral lithiasis in her one remaining right kidney. Nephrotomy and ureterotomy performed by Dr. H. Beck, urologist, effected complete restoration of kidney function and repeated follow-up examinations showed no calculi.

On October 16, 1951, one year following the resection of her rectosigmoid, she complained of intermittant bleeding from her colostomy of two months duration. Barium enema x-ray studies through her colostomy stoma were reported as "essentially normal barium enema study; no gross defects were seen." However, proctoscopic examination through the colonic stoma disclosed a fungating growth 10 cms. from the ostium which proved on biopsy to be an adenocarcinoma, grade II. Inspection of the site of the original carcinoma, the healed perineal wound, failed to reveal any evidence of recurrent malignancy.

Because of the past history of repeated dysentery and the obvious carcinogenic effect of some unknown factor in the colon, a decision was made to do a total colectomy. This was performed on October 30, 1951, and a permanent ileostomy established. The pathologic report was as follows:

Gross Specimen: Examination of the mucosal surface shows extensive disease throughout the entire length of the colon, the gross appearance being that of multiple carcinomas, both polypoid and infiltrating, arising at widely separated foci in a field of diffuse polyposis.

The polyposis takes the form of single sessile and occasionally pedunculated polyps scattered throughout the descending colon and ranging in size from 1.0 to 1.5 cms. In addition there are broad irregular zones of polyposis and papillary hyperplasia scattered throughout the length of the specimen. These range in size from 4 x 3 cms. to 8 x 8 cms., the largest area being situated in the ascending colon approximately 12 cms. above the ileocecal valve. The intervening areas of colon present an intact mucosal surface with no evidence of diverticulosis. The bowel wall appears unthickened to palpation throughout the colon with no evidence of rigidity or stenosis. The ileocecal valve and terminal ileum show no gross changes. Situated 10 cms. from the colostomy orifice is a 3.5 cms. papillary polypoid tumor mass which has been previously biopsied and diagnosed as adenocarcinoma, grade II. On further examination this tumor appears to be limited to the mucosal surface and does not involve the muscularis or serosa. Approximately 18 cms. distal to this point and 28 cms. from the colostomy stoma is a second 4.0 cms. irregular, flat, uncerated, infiltrating tumor which, on sectioning, appears to involve the muscularis of the colon. In the subadjacent mesentery there are four enlarged lymph nodes measuring 0.7 cms. to 1.2 cms. and showing gross evidence of metastatic carcinoma.

In the midportion of the transverse colon is a third tumor mass measuring 9 x 5 cms. which appears papillary and polypoid. On sectioning, this tumor appears superficial and shows no gross involvement of the muscularis or serosa.

At the junction of the cecum and ascending colon, approximately 10 cms. from the ileocecal valve is a fourth tumor mass which measures 3 x 5 cms. and, on sectioning, appears to infiltrate the submucosa and muscularis. This tumor appears flat and infiltrating, showing no polypoid encroachment upon the lumen of the bowel. Regional lymph nodes are taken from the mesentery adjacent each tumor focus for microscopic study. Representative sections are taken from the four larger tumors and polyps from the adjacent and intervening mucosal surface of the colon, and from the grossly normal terminal ileum.

(Microscopic description of the individual tumors is deleted for the sake of brevity).

Sections from the portion of the bowel wall which are uninvolved by polypi or malignancy show an intact well-differentiated mucosal surface with moderate to marked atrophy of the mucosal glands in some areas. There is no evidence of edema, fibroblastic proliferation of fibrosis.

Pathologic Diagnosis: Focal mucosal atrophy; polyposis of colon, diffuse; multiple carcinomas of colon as follows:

1. Adenocarcinoma, Grade I, papillary, polypoid, lower descending colon.

2. Adenocarcinoma, Grade III, ulcerative, infiltrating, with metastasis to regional lymph nodes; upper descending colon.

3. Adenocarcinoma, Grade II, infiltrating, with extension to subserosa; ascending colon.

Up to June, 1953, the patient has done well with her ileostomy. However, as indicated by the pathological report, the chances of permanent cure are remote.

Discussion

Multiple carcinoma of the colon of four or more in number are not common. Welch and Giddings in their paper on carcinoma of the colon include a case of four carcinomas of the colon occurring simultaneously. Marshak reported a case of five carcinomas of the large bowel as did Dixon and Kratzen. Saner and Bargen reported a case of eight primary carcinomas of the colon associated with ulcerative colitis. The relationship of polyposis of the colon and carcinoma is well known. Coffee and Brinig estimated that 75 per cent of carcinomas of the large bowel originate in polyps and that multiple or familial polyposis carries a carcinoma hazard of 66 per cent. Other writers have repeatedly emphasized the high incidence of malignant degeneration in polyposis.

The literature is replete with articles on the carcinogenic effect of chronic ulcerative colitis. Reports from various groups give the incidence of carcinoma in chronic ulcerative colitis as 1.3 per cent up to 6 per cent. In none of the many articles studied however, was there found a suggestion that any chronic irritative disease of the colon, classified or unclassified, may in susceptible persons initiate polypoid growths and malignant degeneration. There seems to be no valid reason why this could not be so.

The etiologic train of events in this case gives rise to considerable speculation. Did the patient have a pre-existing polyposis of fifteen years' duration with diarrhea as a prominent symptom, or did her unclassified colitis and dysentery finally cause a polyposis with malignant degeneration? The history of previous absence of bowel symptoms and the sudden onset of severe dysentery with subsequent chronic diarrhea of fifteen years' duration would rather support the latter theory. Again, what part did the trichomonas infestation play in this chronic colitis? Most parasitologists agree that Trichomonas hominis is a nonpathogen, but two recent reports indicate that this parasite can cause an organic colitis. It is agreed also that it is practically impossible to completely irradicate this infestation with known parasiticidal drugs once it establishes residence in the bowel.

It would seem then that this case serves to emphasize the need for careful and frequent examinations of all patients with chronic unclassified diarrhea or colitis, for they may carry a higher than average susceptibility to carcinoma. Also and most certainly, no case of chronic diarrhea or colitis should be placed in the "unclassified" category until an exhaustive search has been made for the cause.

Summary and Conclusion

A case report is given of four primary carcinomas of the large bowel occurring within a year, apparently originating from malignant degeneration of a polyposis and preceded by fifteen years of chronic unclassified dysentery. The possible implication of a Trichomonas hominis infestation as an etiologic factor is pointed out. The necessity of frequent examinations for carcinoma of the colon of all patients with chronic colitis or dysentery, whatever the cause, is emphasized.

*Medicine's New Platoon System**

LEO E. BROWN
Chicago

I SHOULD like to bring to you greetings from the American Medical Association and its Board of Trustees and to express our grateful appreciation for the cooperation and leadership that the Colorado State Medical Society has provided in the field of medical public relations, particularly in the pioneering that you have done regarding your Board of Supervisors and press-radio-television codes of cooperation.

It is significant that your Scientific Program Committee has seen fit to schedule a discussion of public relations and socio-economic issues. This is a vital part of medicine, and we feel that it is especially important if we are to provide the best medical care.

In discussing medicine's new public relations program, it might be interesting to talk about football a little bit and compare medicine with the current sports season.

I selected the topic, "Medicine's New Platoon System," because in football we used the two platoon system for many years. It has been restricted now because of the advantage it gave to the large school which could afford both an offensive and a defensive team. But I want to compare this platoon system of football with medicine's new system because I think there is a relationship.

You know that our team hasn't changed too much in the last ten years. We still have the same fifty-three state and territorial medical societies and 2,000 county medical societies, with a total membership of around 140,000.

*Guest address delivered October 1, 1953, before the 83rd Annual Session of the Colorado State Medical Society, Denver. The author is Director of Public Relations for the American Medical Association.

However, we have changed in one dramatic instance: we are making every effort to get off the negative and onto a positive, offensive campaign to interpret organized medicine to the general public. Just when and where this change came about isn't really known. Colorado certainly deserves much of the credit. Pennsylvania, Michigan, and California also must be taken into consideration.

By and large the American Medical Association has taken the cue from many of our county and state medical societies in their sound promotion of public relations programs, and it has been encouraging to me over the past three years to observe the support that has been given to the AMA's program.

You know that our schedule this year, if we again use the language of football, is about as tough as it has ever been. And we have to keep in mind the fact that we are not playing just one season. Medicine's team has to be trained so that it can play the entire year 'round, year after year.

We also have to keep in mind the fact that as our team becomes stronger, there will be a growing desire on the part of others to defeat us. Like Notre Dame, we must expect to be criticized in many different areas.

Medicine's offensive program will depend somewhat upon its opponents. Sometimes we will have to vary it—we might have to use the split-T and occasionally the single-wing and the double-wing. There are going to be times when we will have to play in the mud, and other times when we will have to kick a little oftener than some would like. But that will be only until the time when we are sure that our offensive program has reached an effective stage.

Mrs. Hobby's Error

Let me give you two quick examples of what I mean by medicine's offensive program:

Not too long ago, Mrs. Oveta Culp Hobby spoke to the American Hospital Association in California. She made this statement regarding the supply of physicians in this country: "Before World War I, we were graduating approximately 6,000 students, with 1,000 being added each year, which was not keeping up with the increase in population." These figures were totally wrong. We felt that it was our responsibility to point out to the Secretary of Health, Education and Welfare that the figures were incorrect. We informed her that before World War I we had approximately 12,000 students in medical school, graduating some 3,300 students each year. But in this last year, we had over 27,000 students in medical school and more than 6,600 medical graduates. Here we have a 100 per cent increase since World War I in both students and graduates. So we took the offensive in informing Mrs. Hobby of her factual errors regarding medical education.

Taking the Offensive

A letter came into us recently from Midland, Texas. It was from an advertising firm which requested all information available on fee splitting. A druggist in Midland was contemplating carrying on an advertising campaign in opposition to alleged fee splitting in that area. We supposed that his volume of business had fallen off and that he was blaming it on some form of fee splitting being carried on by another druggist. We immediately got in touch with the Texas State Medical Association, which in turn contacted the Texas Pharmaceutical Association, which reached the druggist. The State Association also contacted the local newspaper and obtained a pledge not to run the ads until a thorough investigation was made by a committee appointed by the State Association.

So, here, too, is a positive approach taken in trying to handle a situation before public difficulty arose.

These are examples of what we are trying to do when I say medicine's new platoon system is taking the offensive in trying to solve some of our public relations problems.

We all know that a team is only as strong as each individual player and that it has to depend upon the willingness of those players to participate. And a winning combination, whether in medicine or football, depends somewhat upon the training of the team. Perhaps one of medicine's

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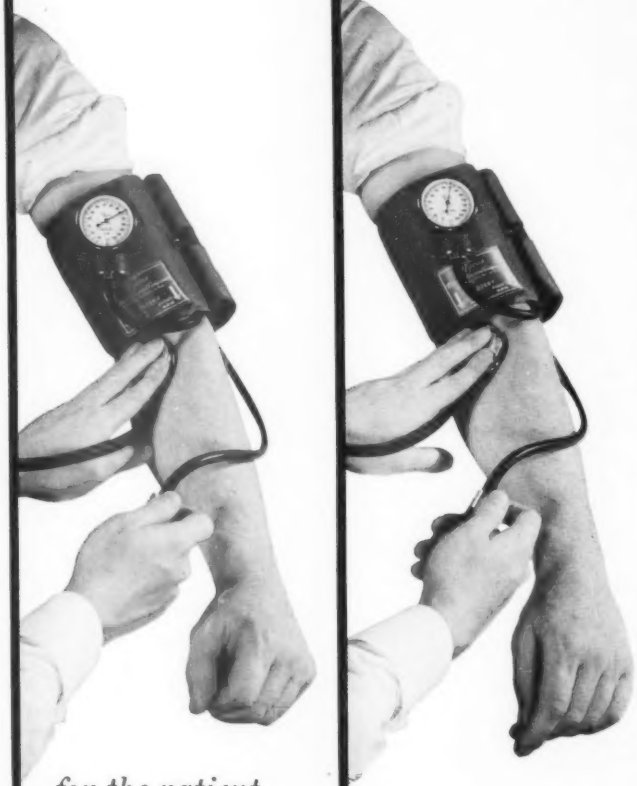

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1. Hafkenschiel, J. H., and Lindauer, M. A.: Circulation 7: 52, 1953.
2. Schroeder, H. A.: Circulation 5: 28, 1952.
3. Riven, S. S., Pocock, D. G., Kory, R. C., Roehm, D. C., Anderson R. S., and Meneely, G. R.: Am. J. Med. 14: 160, 1953.
4. Taylor, R. D., Dustan, H. P., Corcoran, A. C., and Page, I. H.: Arch. Int. Med. 90: 734, 1952.

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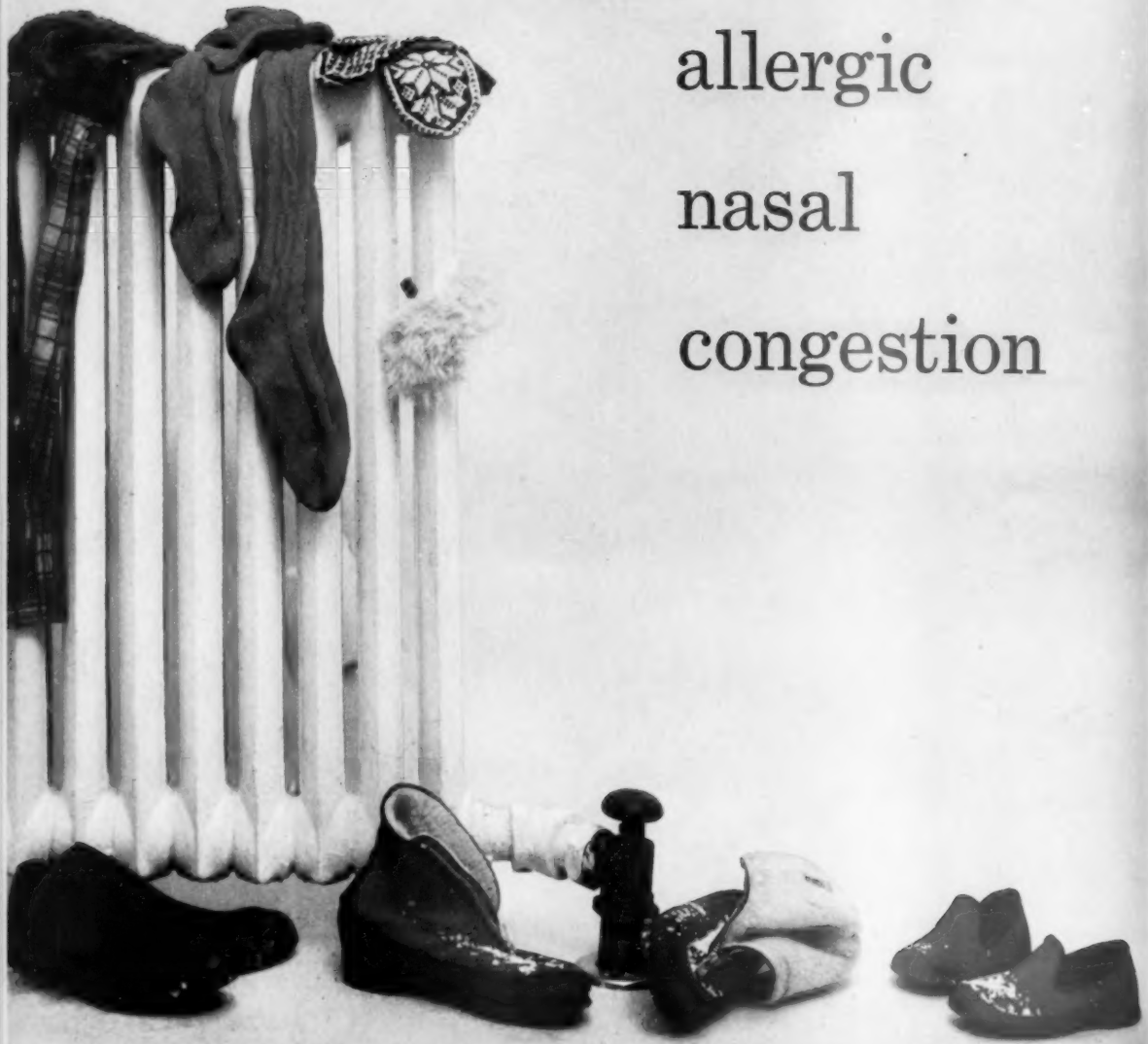


greatest weaknesses today is the fact that only half of our team is playing. How many of you have gone to your county medical society meetings to find less than half of your total membership in attendance, less than half really interested in the socio-economic activities of the society and taking an active part on your committees to improve the relationship of your society with the public?

That is one of medicine's weaknesses throughout the country, and we hope that we will be able to take the offensive by encouraging more physicians to become active in society work.

There also must be a desire on the part of the team to play together. We know there have been difficulties in the past regarding professional jealousy. Thank goodness, in recent years the situation has changed, and physicians have demonstrated their willingness to play together far more than ever before. Teamwork is essential to a successful program.

The next step in our program depends upon each individual player's knowledge and ability to execute the basic fundamentals of the game. This is our beginning point. If medicine's public relations program is going to be based upon the total of each individual physician's public relations program, it is absolutely necessary that he have some training in the basic fundamentals of the game.

A New Training Manual

As an aid to improving the personal public relations of the physician, we have designed a new public relations manual. It is called "Rx Public Relations—The Human Side, The Business Side, of Medicine." Each of you will receive a copy of this manual within a week or two*

We feel that this will be a training manual for each individual physician, and I appeal to each of you to take the time to read it and acquaint yourselves with the suggestions contained therein. They are not suggestions by laymen in this particular field. They were made by fifty physicians throughout the country who are vitally interested in medical public relations. I hope you not only read it, but also bring it to the attention of your friends in the profession.

If we are going to have a winning team, it is essential that our players know how to execute some of the offensive plays that we plan to promote.

What are some of these offensive plays that medicine has adopted?

One is explaining the cost of medical care. Others are increasing the supply of physicians, developing emergency night call systems, intensifying our fight against quacks and cults, expanding our voluntary health insurance program, participating in community activities, and making known the position on veterans medical care taken by organized medicine.

These are some of the offensive plays that have been adopted by medicine over the past few years. They are effective plays. It is essential that our members become acquainted with them in order to make progress, so that when the quarterback calls the signals, they will know just what play to execute.

I want to deal just briefly with a couple of these plays.

One is the cost of medical care. In explaining the cost of medical care, we appreciate that the general public has voiced many criticisms. It is only natural, because if we analyze this, we find that we are asking people to pay for something they did not want, something they did not ask for, and something for which they have little tangible results to show in return, except perhaps in obstetrics.

Furthermore, the physician has been blamed not only for the cost of his own services, as your own Dr. Cyrus Anderson explained at one of our public relations meetings two years ago, but also for the cost of hospitalization and drugs.

If we are going to take the offensive on this particular program by carrying the message on the cost of medical care to our patients, it is absolutely essential that a frank discussion of fees be encouraged with the patient, because the major difficulty involves misunderstandings, rather than the cost of medical care.

In order to be successful in promoting

*Mailed to every A.M.A. member in October, 1953.

this offensive program insofar as costs are concerned, it will be absolutely necessary for all of our members to learn this play and participate in it by explaining the costs of medical care.

Colorado Complimented

You have done an excellent job here in Colorado regarding your emergency call systems and your Board of Supervisors. As I mentioned before, you have led the way. But we will have to continue to use this offensive approach in the promotion of our over-all public relations program.

Naturally we are going to have some members on our team who, unintentionally, will not abide by the rules of the game some of the time. There are others, perhaps a very few members, who, intentionally, will violate the rules. Perhaps there will be some clipping from behind, and perhaps some holding on both the offensive and the defensive. We realize that these situations exist. And when I refer to violating the rules of the game, I mean violations of the principles of Medical Ethics.

All of medicine must realize, as you have done in Colorado, that all the money spent in trying to improve public relations will go down the drain unless we conscientiously discipline those members who repeatedly violate Medical Ethics. Just as the football team, the entire eleven men, are put back five, ten or fifteen yards for a violation by one man, so medicine is being set back in its public relations program by the individual violations of the principles of Medical Ethics. One of our major tasks, inside the profession, is to impress upon all members that they have a responsibility to abide by that code.

What about our defensive platoon? It is a well-known fact that the best defense is a strong offense and that a winning team tries to keep possession of the ball as much of the time as possible. However, we also know that occasionally we shall have to kick, and at times take the defensive. When we do this, we must be prepared by having physicians adequately informed to defend themselves on all issues.

It must be remembered that certain individuals and organizations in this country, who have very able "running backs," are going to continue their program for the promotion of compulsory health insurance. We also have a number of critics who are going to have to be answered on occasions, and we are prepared when such occasions arise to answer them directly and forthrightly.

Let's not forget, too, that we will be harrassed by some Monday-morning quarterbacks in the profession who do not like what has been going on, but have refused to participate in the game. The only way to handle this particular group is to encourage them to take an active part in medical society activities and to assign them major responsibilities which will open their eyes to the society's problems and objectives. In other words, put them to work, and you will get them on your side.

There is one other phase of this particular program that is important. I am not speaking now from the standpoint of the American Medical Association, or your own society, or societies here in Colorado. If we are going to keep our team in play, it will be necessary to finance that team adequately. To maintain and develop an offensive program for medicine, we must be willing to finance that program. As a matter of fact, such a course will be much cheaper in the long run, for the ultimate gain in public relations profits will far exceed the expenditure in dollars.

Now who are the coaches of the American Medical Association teams? The AMA? I think not. The coaches in this offensive program that medicine is launching are your own Board of Trustees, your own House of Delegates and their counterparts in all the other state medical societies. They set the policy for your respective associations and carry it on to the American Medical Association's House of Delegates.

In conclusion, I would like to emphasize that the AMA is not playing this game for the personal benefit of the individual physician. We have to stress this at all times with the general public. We are playing this game not to benefit the physician, but to serve the interests of better health and medical care for the entire American population.

Retroperitoneal Approach To Lumbar Disc

EUGENE B. LEY, M.D., and W. D. THURSTON, M.D.
Pueblo, Colorado

WITH the introduction of discography, it became apparent to us that a logical and perhaps a more efficient approach to the problem of ruptured nucleus pulposus in certain selected cases should be through the retroperitoneal route. Accordingly, we selected what we believed to be an ideal case for this procedure and it was carried out with very good results. We were so enthusiastic with our results that we immediately reviewed the literature to see if we actually had an original contribution. We were pleased to learn Dr. Paul Harmon (Results From the Treatment of Sciatica Due to Lumbar Disc Protrusion; Surgery, 80:6, p. 829, 840:1950) of Los Angeles reported three cases of ruptured nucleus pulposus that he had successfully treated by this procedure; and, since this time, he has reported doing some fifty cases and has produced a movie dealing with this technic. Love and Moore (Transperitioneal Approach to the Intervertebral Disc in the Lumbar Area, Surgery 127:537:1948) described a transabdominal approach to the lumbar disc, but this is not considered practical. Since our original case was done, we have an additional twenty-four cases in which we have successfully removed a degenerated protruding disc from L-4 or L-5 or both by this approach.

Indications

The indications for this procedure are restricted to only those discs with minimal protrusion. We agree with Dr. Harmon in emphasizing the point that a large protrusion which fills the canal posteriorly is not amenable to the retroperitoneal approach. We believe that a myelogram should be done as a preliminary procedure to rule out the presence of a neoplasm when clinical findings and conservative management of the patient have definitely indicated that surgery is the most desirable treatment. Having obtained a negative myelogram, or a myelogram with a minimal defect, thus ruling out neoplasm or a massive posterior protrusion of a disc, we prepare these patients for surgery.

Operative Technic

It has been our custom to use a portable bucky on a regular operating table and to place the patient on his right side on the bucky before the anesthetic is started. An operative table with a built-in bucky such as a GU table is suitable. This position has two distinct advantages. First, it affords better exposure as the viscera tend to fall away from the operative field; and secondly, a lateral discogram is the most definite view. A left oblique muscle splitting incision is used. We prefer this to the transverse or vertical incision. After the transversalis fascia is divided, beginning at the iliac crest and working toward the midline, the peritoneum is reflected and the retroperitoneal space is entered. The retroperitoneal fat in this space is abundant and separation of the peritoneum from the posterior structures is carried out with ease; the ureter is retracted forward with the peritoneum and its blood supply is not disturbed. As the midline is reached, exposure of the vertebral bodies is facilitated by use of blunt dissection. A moist stick sponge is effective in this maneuver. The bifurcation of the aorta is usually found about the level of the body of the third lumbar vertebra. The fourth interspace is best approached slightly to the left of the midline and the left common iliac artery and its accompanying vein are easily retracted to

either the right or left side in order to gain adequate exposure of the interspace. The vessels are gently retracted by use of a small retractor. At the level of the fifth interspace, one will be working between the common iliac vessels and here it is found that the common iliac vein usually lies medial to the artery and it is retracted laterally or to the left to gain adequate exposure of the fifth interspace. Having exposed the two interspaces, where abnormal discs most frequently develop, a long spinal needle is introduced directly into the interspace and from 3 to 5 c.c. of 20 per cent diodrast is injected directly into the space. It is of interest to note that the injection of a normal disc requires considerable force; whereas, the injection into a space containing a degenerated disc is carried out with relative ease. Before proceeding, x-rays are taken and the discogram is studied. Having determined the level of the ruptured disc, a large trap door type of incision is made through the ligament and annulus fibrosa, and by swinging this open, the interspace is entered and the nucleus is visualized. Frequently, degenerative nucleus material wells up into the incision just as so often is encountered when one approaches the disc space through a laminectomy. The space is thoroughly cleansed of degenerative material, care being taken not to go beyond the posterior ligament. We have found a blunt nosed pituitary ronguer to be very effective and safe in debriding this joint. Having removed all degenerated disc material, a curette is used to remove the hyaline plate from the body of the adjacent vertebrae. In some recent cases, we have taken additional x-rays after the degenerated nucleus has been removed to determine whether the protruding portion of the degenerated disc as seen by discogram had been successfully removed (see Fig. 1). Being able to demonstrate this successfully gives us more confidence that the offending agent has been excised. A rasp is used to groove the adjacent vertebral bodies into which the bone graft is fit. A piece of iliac bone is obtained from the crest of the ilium (which, incidentally, is easily obtained by retracting the lateral flap of the incision and thus making an additional skin incision unnecessary). The piece of iliac bone must be wide enough to fit snugly between the bodies of the vertebrae into the groove fashioned by the rasp. Small fragments of spongy bone is packed around the graft. The incision is closed in layers, using cotton throughout. Great care must be exercised in closing the transversalis fascia. Postoperatively, the patient is encouraged to sit up the next day and a low back brace is fitted to the patient and is worn for a period of three to six months, or, until fusion has been established by x-ray evidence.

Discussion

This method of spinal fusion is not new and, in fact, it was advocated by Kellogg Speed in 1917. It has been conceded by some of the authorities on the subject that anterior fusion is the most efficient manner of fusion of the lower vertebral column; because, as Speed has pointed out, about 20 per cent of the patients present spina

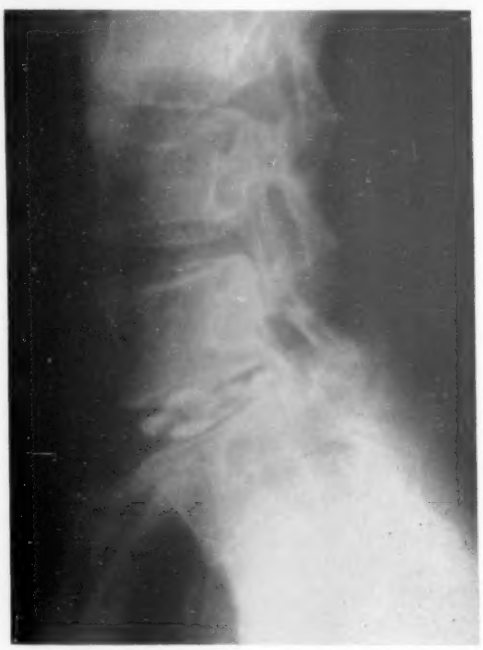


Fig. 1. Positive discogram showing posterior protrusion of disc material.

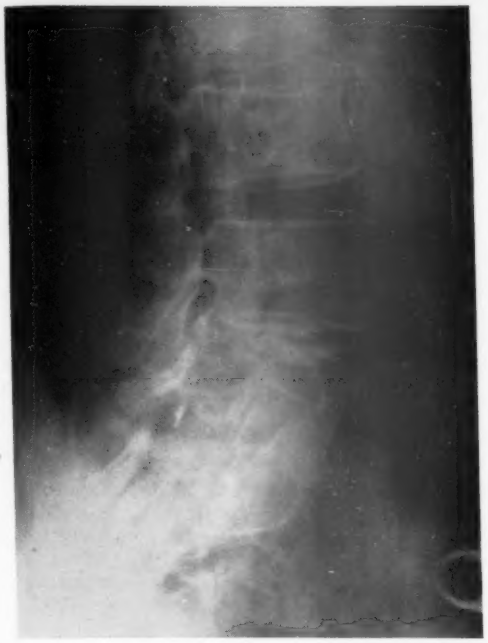


Fig. 2. X-ray examination of the interspace showing positive discogram in Fig. 1 taken immediately after the space had been opened and the disc removed and the disc space curetted. Note that in Fig. 2 the posterior protrusion is definitely absent (the dense radiopaque material immediately posterior to the discogram is pantopaque which was not completely removed at the time of the myelogram).

bifidia occulta associated with spondylolisthesis which interferes with proper placement of the graft when the approach is made posteriorly. Furthermore, it is more desirable to fuse supportive structures, rather than protective. In spite of this obvious advantage, this procedure has not been popularized because of the contention that the approach as advocated by Speed, Mercer, Jenkins, and Burns had been transperitoneal and therefore carries a greater operative risk. This is true. The retroperitoneal approach, however, is not accompanied by shock, does not subject the patient to postoperative intra-abdominal adhesions and it has been our experience that these patients convalesce as rapidly as an uncomplicated appendectomy. The average operative time, using x-rays which delay the procedure an average of fifteen minutes, is one hour.

The discogram undoubtedly will make the surgical treatment of degenerated nucleus pulposus a more accurate procedure. Many surgeons are hesistant to use this added diagnostic procedure for fear of causing protrusion of a disc when injecting the space by the usual approach through the dura. It may be approached obliquely or paravertebrally as in the technic used to inject the sympathetic chain. However, this is a difficult, painful, and time-consuming procedure even when the flouroscope is used in conjuction with the approach. We feel the discogram is invaluable when used as we have described it in this paper. The second, third, fourth and fifth lumbar spaces are readily injected, studied, and treated, if necessary, by this method. Furthermore, the x-ray study of space after the injected disc has been removed offers an additional advantage to the surgeon to assure himself that adequate excision of the degenerated nucleus has been accomplished.

'54 Radio and TV Plans Announced

America's physicians will be "on the airways" more than ever during the new year as the A.M.A.'s Bureau of Health Education announces plans for new radio and television programs. In response to the trend of listening audiences toward local radio shows, emphasis will be placed on locally-organized programs both in radio and television.

Present television plans call for a thirty-minute film relating to some aspect of medical care to be produced jointly by the Bureau and the Department of Public Relations. This film probably will be available about the time of A.M.A.'s June meeting. In addition, several new sequences will be developed in the "What to Do" series—the five-minute TV films which star popular woman's commentator, Nancy Craig, explaining safe procedures to follow in home emergencies.

Inaugurating a new service for state and county medical societies, the Bureau also is planning the preparation of "script-clip packages" for television. These packets will contain outline scripts which can be narrated by local doctors while film clips illustrating the topic are shown on the TV screen.

Regarding radio plans, the Bureau will concentrate on new electrical transcriptions during 1954. These will be released approximately at the end of April, June and October. The first will be devoted to science and supersition, and other topics will be announced later.

The Washington Scene

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

Although the budget, defense and farm policy are monopolizing Washington headlines, Congress is paying more than casual attention to the health and social security fields. In these, as in other legislative areas, it has for its guidance a specific program, laid down by President Eisenhower in his various messages during the first few weeks of the session. The question now is whether this closely-divided Congress will have the time and/or the inclination to follow through on everything the Administration wants.

Before Congress settled down to its task, the President met with a group of American Medical Association leaders, who discussed with him the association's position on several important pieces of legislation. Present at the White House meeting, in addition to Mr. Eisenhower and Sherman Adams, Assistant to the President, were A.M.A. President Edward J. McCormick, Trustees' Chairman Dwight H. Murray, President-elect Walter B. Martin, and Washington Office Director Frank E. Wilson.

Congress got into the health and welfare field with no waste of time. Within five days after Congress reconvened the House Interstate and Foreign Commerce Committee, under the chairmanship of Rep. Charles Wolverton (R., N. J.), began an exhaustive series of hearings on voluntary health insurance, further evidence that the Administration is determined to get some action in this direction.

Chairman Wolverton as long as four years ago was interested in legislation to help prepaid insurance programs extend their coverage and increase their benefits. In 1950 he incorporated his ideas in a bill, but it was not acted upon by the committee and was not revived until this year. Now the atmosphere is much more favorable for Mr. Wolverton's proposal. Not only is he chairman of the committee and his party in control of Congress, but his ideas have strong support from the Administration.*

Basically the Wolverton idea is an FDIC for voluntary health insurance. In about the same way the Federal Deposit Insurance Corporation insures bank deposits up to a certain limit, the Wolverton program would insure (or re-insure) various types of hospital, surgical, and medical insurance programs. The proposal is for the federal government to set up a national health insurance underwriting corporation. To keep the corporation going, the member plans would contribute a certain percentage of their gross receipts, possibly 2 per cent.

With the national corporation underwriting unusual risks, the individual programs could offer catastrophic or "complete" coverage. By scaling individual premiums to the family income, the member plans also could offer protection to families with very low incomes. The national corporation would pay possibly two-thirds of each subscriber's claim in excess of, say, $500 or $1,000 in any one year.

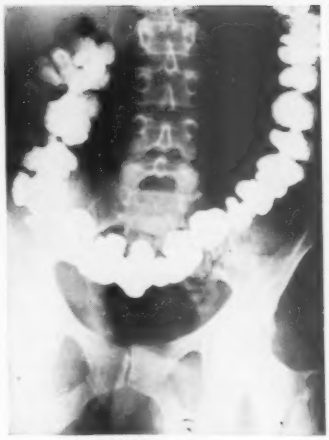
Another piece of legislation which is receiving favorable attention would also help families with their medical expenses—a proposed liberalization of income tax deductions allowed for medical expenses. Under present law, only that part of medical expense exceeding 5 per cent of taxable income may be deducted. The pending legislation would drop this to probably 3 per cent, and raise or eliminate the maximum limit. In past years scores of bills pointed in this direction have been introduced. If this is incorporated in the general tax overhaul legislation, it is believed to have a good chance of enactment.

Secretary Hobby's Department of Health, Education and Welfare is firmly behind a proposal to have the federal government show more leadership in vocational rehabilitation of the handicapped.

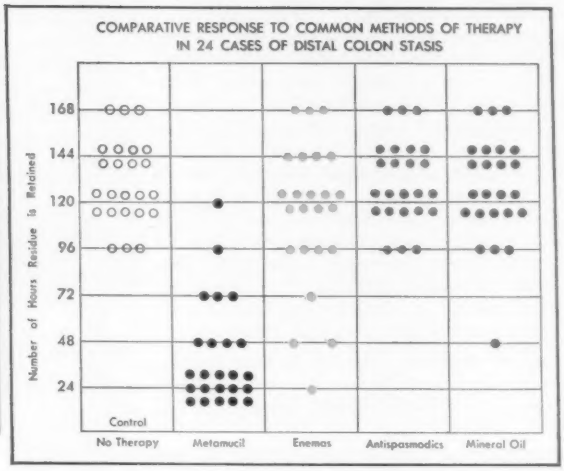
At this writing it is too early for any good indication as to whether physicians will be brought under social security. The Administration's bill would blanket in most self-employed groups, including dentists, attorneys, architects and farmers, in addition to physicians. Rep. Carl Curtis (R., Nebr.), chairman of the subcommittee feels the same way. However, a substantial number of the members of the House Ways and Means Committee, which must pass on the bill, which investigated social security, apparently are known to feel that compulsion should not be used on groups that do not want Old Age and Survivors Insurance.

From all indications available during the first few weeks of Congress, a showdown fight may be unavoidable on medical care for military dependents. Defense Department, with support from the President, wants dependent care extended and made uniform among the three services, with military physicians carrying as much of the responsibility as they can. Under the Defense Department plan, dependents who could not be taken care of at military installations would be

*See "Political Health," Page 150.



Distal Colon Stasis



Management of Distal Colon Stasis with Metamucil®

The "irritable colon" resulting in distal colon stasis is a hard-to-manage by-product of many abdominal or stress conditions.

Roentgen evaluation of the commonly used methods to combat colonic stasis has shown the value of Metamucil because of its lack of irritation and its high degree of effectiveness* in this most prevalent type of stasis.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It produces smooth fecal bulk necessary to incite the normal peristaltic reflexes, without causing irritation, straining, impaction or interference with the digestion or absorption of vitamins.

The average adult dose is one teaspoonful of Metamucil powder in a glass of cool water, milk or juice, followed by an additional glass of fluid if indicated. This amount of fluid is essential for the production of "smoothage."

It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE *Research in the Service of Medicine*

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis. Rev. Gastroenterol. *19*:154 (Feb.) 1952.

allowed to obtain their care from private sources, with the government paying almost all of the cost.

The American Medical Association agrees with the Defense Department that all dependents should receive medical benefits as nearly uniform as possible. However, A.M.A. contends that wherever possible dependents should use private physicians and private hospitals, and that the military personnel and facilities should be employed only where civilian facilities are inadequate.

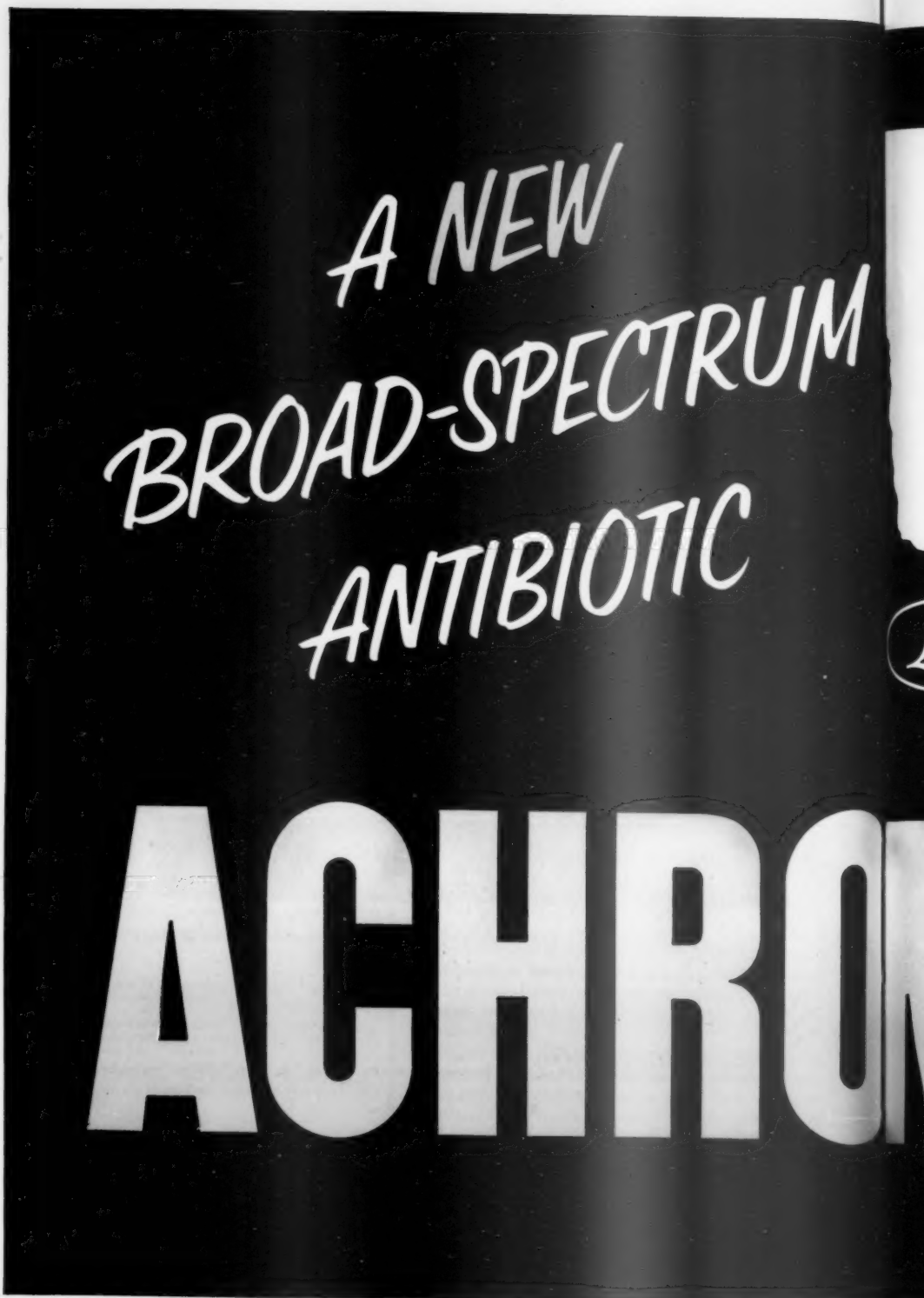
National Affairs

National Rural Health Conference

Here's a rundown of the principal "plays" to be called at the ninth National Conference on Rural Health March 4-6 at the Baker Hotel, Dallas, Texas. Sponsored by the A.M.A.'s Council on Rural Health, this year's program will be built around the theme—"Let's Put More 'U' in CommUNITY."

Star "players" on the first-string team include: Thursday afternoon kick-off—"Deep in the Heart of . . . Communities," presentation by Charlotte Rickman Bensen, health education consultant for Medical Society of North Carolina, showing how communities can organize at the grass roots to work out their health problems . . . Thursday evening "dutch treat" dinner—Speech on "Leonardo da Vinci" by Chauncey Leake, Ph.D., vice president of University of Texas School of Medicine . . . Friday morning—discussion of nutrition problems showing the relationship of nutrition to humans with a presentation by John B. Youmans, M.D., dean of Vanderbilt University School of Medicine and member of A.M.A.'s Council on Foods and Nutrition . . . Friday afternoon—"Health Insurance—What, How and Why," presentation by Lambert Schultz, staff executive of Provident Life and Accident Co., explaining what's contained in the "fine print" of an insurance policy.

Friday evening's schedule includes—George D. Scarseth, director of research of American Farm Research Association, speaking on "Soil, Civilization and Our Health," showing the relationship of soil nutrients to individual health . . . Saturday morning's discussion sessions include: "Cuties, Cookies and Community Service," with Mrs. Esther Thornton, superintendent of Washington County Community Hospital, Akron, Colo., showing a film on training nursing students . . . "Home-Aid Hospital," with Gordon Maxam, rep-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ACHROMYCIN is now available in 250 mg., 100 mg., and 50 mg. capsules, SPERSOIDS® 50 mg. per teaspoonful (3.0 Gm.), Intravenous 500 mg., 250 mg. and 100 mg. Other dose forms will become available as rapidly as research permits.

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AVERAGE ADULT DOSE: 200 mg. every four to six hours. You'll find *Specially-coated* ERYTHROCIN tablets (100 and 200 mg.) in bottles of 25 and 100 at all pharmacies. Abbott

1. Grigsby, M. E., et al., Antibiot. & Chemother., 10:1029, October, 1953.

ALSO FOR CHILDREN: Tasty, Stable *Pediatric* ERYTHROCIN Suspension

resentative of City of Lake Preston, S. D., explaining how a community raised funds for its own hospital . . . "A Doctor's Answer to a Community Need," with J. Paul Jones, M.D., Camden, Ala. . . . "A Planned Approach to Doctor Distribution," with Chester U. Callan, M.D., chairman of Rural Health Committee of Texas Medical Association, describing his state's placement service . . . "U" with Aubrey D. Gates, field director of A.M.A.'s Council on Rural Health, giving a summary of the conference. . . . Winding up the conference at Saturday's noon luncheon, Edward J. McCormick, M.D., president of the A.M.A., will explain what the A.M.A. is doing in the rural health field.

A.M.A. Offers Child Training Radio Series

How parents and their children can live happily together is the theme of a new series of radio transcriptions available Dec. 15 from the A.M.A.'s Bureau of Health Education. "Train Up a Child" is concerned not only with the physical adjustments of having a child but also with the emotional adjustments and mental attitudes involved in the family group. In this thirteen-program series, Dr. Woodruff L. Crawford, noted pediatrician and chairman of the A.M.A.'s Committee on Maternal and Child Care, is interviewed by Radio Commentator Radcliffe Hall. The simple, down-to-earth discussions cover such varied subjects as physical care of the baby, mental adjustment of husband and wife toward having a baby, mental adjustments between parents and child, discipline, and so forth. Dramatic sketches giving examples of the situations which Dr. Crawford describes have been woven into the presentations. This series has been approved for public consumption both by the A.M.A. and the American Academy of Pediatrics.

REGIONAL MEETING ON VETERANS CARE

More regional conferences on veterans medical care will be held during 1954 under the sponsorship of the A.M.A.'s Council on Medical Service through its Committee on Federal Medical Services. These meetings have a fourfold purpose: (1) Develop a working liaison with state society committees concerned with veterans' problems; (2) acquaint an increasing number of physicians with A.M.A. policy and the facts regarding veterans care; (3) learn the local situation regarding this policy in various states, and (4) discuss ways of carrying out the instructions of the House of Delegates which adopted a firm stand on veterans medical care at its meeting last June.

The present schedule calls for meetings early in the year: February 19, Denver; February 21, Portland, Ore.; February 27, Omaha, and in March, Boston and either Chicago or Indianapolis. Four similar conferences were held last year in Dallas, Atlanta, New York and Washington, D. C.

Blue Cross-Blue Shield

Hawley Talks Turkey

Dr. Paul R. Hawley, Director of the American College of Surgeons, lays it on the line. In an address to the United Medical Service of New York, he said:

"Blue Cross is wholly at the mercy of hospitals and doctors and must rely solely upon them for protection against abuses. It is ordinarily the doctor who says when the patient goes to the hospital, what services shall be given him while he is there and when he shall leave the hospital. The medical profession has been slow to realize that in its hands, almost exclusively, rests the sucess of voluntary prepayment of the costs of medical care. Voluntary health insurance can easily become too expensive for people in the low income group.

"Blue Cross earnestly desires that every member be given every necessary service in the hospital. But unless wholly unnecessary abuses are curbed, Blue Cross may be priced out of its most important market.

"Blue Cross has been caught between the upper and nether millstones of spiraling costs and increasing utilization. We can't keep this up forever. One of these days Blue Cross is going to be too expensive for poor people. When that day comes we are going to have compulsory health insurance."

Dr. Hawley advocates:

"1. Education of doctors, hospitals and the public that abuses of health insurance only raise the cost of protection, and that this cost can be kept low only be restricting its use to necessities.

"2. Re-evaluation of hospital care, and elimination of services which are purely luxuries and do not contribute significantly to the recovery of patients."

Changing Times

Changing Times, the Kiplinger magazine, publishes an informative article on health insurance.* The situation is difficult for the consumer. There are over five hundred companies writing health insurance, and there are thousands of policies available—no two alike. Blue Cross has different contracts in its many different Plans, and the monthly premium for family coverage

*December, 1953.

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Glazebrook, A. J., Brit. M. J.,
2:1328,(Dec. 20) 1952.

ranges from $2.80 to $6.75. The benefits are correspondingly diverse.

A family should expect to pay about 4 per cent of its income for medical and dental expense. Yet some of this expense can be budgeted, and there is no point in paying an insurance carrier a commission to cover routine bills. Insurance should be for big bills and serious illness. This type of insurance will cost the family 2 or 3 per cent of take-home pay, and it is a MUST with any provident family.

Don't be talked into insurance, says the writer. If you have a particular company in mind, ask for the names and addresses of some of your neighbors whose claims have been paid, then ask them how they fared. "If possible, belong to your local Blue Cross hospitalization plan. Even if you happen to work for a company whose employees are not members of Blue Cross, make inquiries." The writer suggests a group in a church, or lodge, or club, as an alternative. In any event, group participation is advised, and Blue Cross and Blue Shield are clearly the preference for hospital and health insurance.

DR. LOWELL HONORED

The annual Rubinsohn Award for the best paper on the colon and rectum, presented before the Philadelphia Proctologic Society during 1953, was formally presented to Dr. Edward J. Lowell, Jr., of Denver, January 8, 1954, at a formal ceremony in the Union League Club of Philadelphia. The winner of the award was determined by a vote of the Society, and the winning contribution is published in the January, 1954, issue of the monthly journal, "Surgery."

The paper is entitled "Villous Papillomas of the Colon and Rectum," based on a study of 1,200 cases of cancer of the bowel which underwent surgery over a five-year period. The paper is one of several written by Dr. Lowell while he was associated with Dr. Harry E. Bacon at Temple University in Philadelphia. The prize consists of one hundred dollars and an engraved certificate.

ACS SECTIONAL MEETING IN OMAHA

The American College of Surgeons announces a four-day sectional meeting featuring clinics and specialty programs to be held March 1-4 at the Hotel Fontenelle in Omaha. All members of the medical profession are invited.

The medical faculties of Creighton University, the University of Nebraska and seven Omaha hospitals are cooperating to insure a successful program. The meeting will cover general surgery, ophthamology, obstetrics and gynecology, otolaryngology, thoracic surgery, urology, and orthopedic surgery. Operative and nonoperative clinics will be held at various hospitals Monday through Wednesday mornings.

On the evening of March 1, there will be a motion picture symposium including films shown at the recent Clinical Congress. The participants

will include Dr. Henry Swan, Denver, on "Cardiac Arrest." Dr. Ervin A. Hinds, Denver, will preside at a session on general surgery the morning of the second day, following the hospital clinics.

Following a dinner meeting March 2, at which Dr. Paul R. Hawley, director of ACS, will speak, there will be a cancer symposium over which Dr. H. Mason Morfit, Denver, will preside. Among those participating in a general surgery session the afternoon of March 3 will be Dr. John B. Grow, Denver, discussing "Bronchiectasis and Lung Abscess." Moderating a panel discussion on urology at a March 3 afternoon meeting will be Dr. T. Leon Howard, Denver. The afternoon of March 4 will include a program on pediatric surgery and Dr. Swan will be one of the participants.

Obituary

LEONARD MATHEWS VAN STONE

Dr. Van Stone died December 20, 1953, at St. Joseph's Hospital in Denver. He was born November 21, 1887, in Denver and had retired from active medical practice in 1951 because of ill health. His specialty was tuberculosis.

Dr. Van Stone graduated from Manual High School and then attended Colorado College where he was a star baseball pitcher. He attended Harvard Medical College, graduating in time to serve in France with the Harvard medical unit during World War I.

He was a member of the Denver Country Club, the University Club and an active member of the Colorado State Medical Society. Dr. Van Stone is survived by his wife, Mrs. Emilie Van Stone, of 4730 East Sixth Avenue, and a brother, Dr. Harold D. Van Stone.

Obituary

C. C. RICH PUGMIRE

Dr. C. C. Rich Pugmire, Salt Lake City physician, died in a Salt Lake hospital after a lingering illness, November 20, 1953.

Dr. Pugmire was born in St. Charles, Idaho, July 7, 1880. He served a two year mission in England for the Church of Jesus Christ of Latter Day Saints before he began the study of medicine. He received his M.D. Degree from the Medico-Chirurgical College of Philadelphia in 1910. He launched his career with a general practice in Morgan, Utah, and eleven years later he specialized in eye, ear, nose and throat treatment in New York and Europe and then located in Salt Lake City, Utah, where he practiced for twenty-five years. He retired five years ago and moved to Southern California but returned to Salt Lake City a few months ago.

He was a member of the Salt Lake County Medical Society, Utah State Medical Association and the American Medical Association.

He is survived by his widow; a son, Dr. Adrian S. Pugmire of Salt Lake City; one daughter, Mrs. Mildred Lundquist of Covina, California; three grandchildren and two brothers.

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Correspondence

Irritable Colon Syndrome

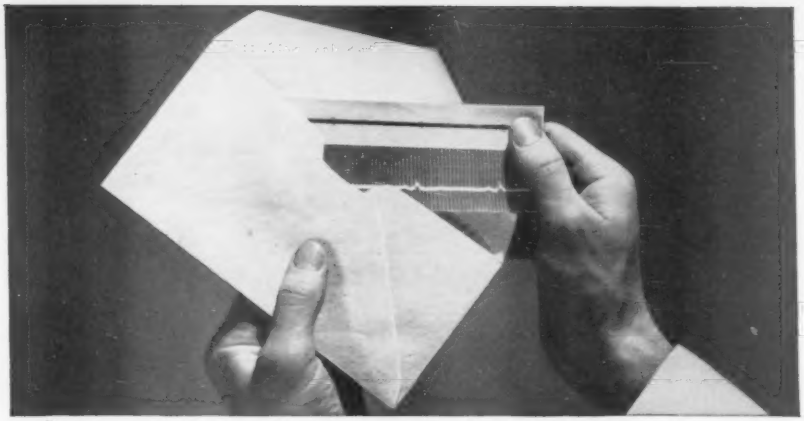
January 8, 1954.

To The Editor:

The following comments occur to me as a result of reading the article, "The Diagnosis and Treatment of the Irritable Colon Syndrome," by Edward J. Donovan, M.D., in the December, 1953, issue of the Rocky Mountain Medical Journal.

The author defines this important syndrome properly as a functional disturbance of the colon in which no definite organic colonic disease can be found. He describes **decreased** as well as **increased** "irritability" of the colon as a manifestation. Furthermore, he correctly points out that the transit time from the stomach to the colon, a function of the small bowel, is frequently altered in this syndrome. In the opinion of other gastroenterologists and radiologists, the distal esophagus and stomach also may share in producing the distress experienced by these unfortunate patients. Therefore, would it not be better for us to term this syndrome "functional gastrointestinal or bowel distress" as W. L. Palmer has done, recognizing that at times any one of the several components of the gastrointestinal tract may predominate in the symptomatology?

Since the diagnosis is one of exclusion, and this it should be until we understand gastrointestinal physiology much better than we presently do, most gastroenterologists and radiologists cannot concur with the practice of examination of the colon without adequate preparation. All physicians who undertake roentgen examinations of the gastrointestinal tract have the very heavy responsibility for detecting the organic disease which frequently masquerades as functional bowel distress. Among these conditions is early polyroid carcinoma of the colon—a highly curable disease—and others, such as ulcerative colitis. In these organic diseases there are radiologically provable lesions which can be obscured by feces. These lesions can be demonstrated provided the patient has been properly prepared and presents the diagnostician with a clean colon, and provided, of course, that the examination is adequate. Your attention is called to the many new developments and vast labors now directed towards discovering early lesions of the colon, as illustrated in the Journal of the American Medical Association, December 19, 1953. The success of all of these newer technics still depends on adequate preparation of the colon for the examination. Let us, therefore, do the very best we can to demonstrate organic lesions which might produce the syndrome, and leave the diagnosis of



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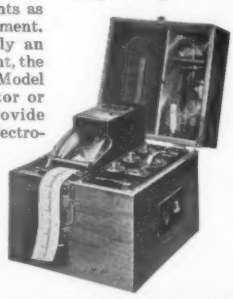

With ever-increasing knowledge of interpretation, the Cardiologist of today demands an Electrocardiograph that produces records, the accuracy of which he can depend upon for his most exacting diagnosis. Accuracy has always been the "must" factor in Cambridge Standard Electrocardiographs. No feature, no matter how desirable it may seem, is ever adopted if it impairs in the slightest degree the fundamental accuracy of these fine instruments.

The "Simpli-Trol" Model, a portable instrument, is contained in one case 8" x 10" x 19" and weighs only 30 lbs. Other Cambridge Standard String Galvanometer Electrocardiographs are the Mobile and Research Models ... all of which may be arranged to record heart sounds, pulse and electrocardiogram simultaneously.

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functional bowel distress where it safely belongs, as a last resort.

Special examination of the colon to diagnose functional distress following an adequate examination to exclude organic lesions, with conclusions based on the incompletely evaluated signs listed by the author, are therefore unnecessary. They are expensive to the physician and patient in time and money, and in exposure to irradiation. Such examinations may be justified as research procedures which certainly should be conducted in order to better understand the disease.

I agree heartily with the author's emphasis on the importance of this syndrome, and in his sensible and practical treatment of the condition. I have seen it work!

RAYMOND R. LANIER, Ph.D., M.D.,
Professor, Department of Radiology,
U. of Colo. Medical Center.

A.M.A. EXHIBIT IN NATION'S CAPITAL

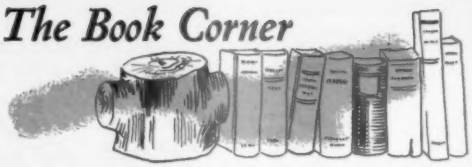
By special invitation of the museum, the American Medical Association will display its exhibit, "The Organs of the Human Body," at the Smithsonian Institution in Washington, D. C., during 1954. After this year, this exhibit will be available for showings in other museums throughout the country.

A new exhibit—"The Physician's Responsibility in Highway Accidents"—calls the doctor's attention to the fact that he should warn patients about the dangers of driving while under the influence of sedatives, antihistamines or anticonvulsive drugs. For professional showings only, this exhibit may be booked through the A.M.A.'s Bureau of Exhibits.

AA PHYSICIANS TO MEET

The International Group of Doctors in Alcoholics Anonymous has announced its fifth annual meeting, to be held May 14 to 16, 1954, at the Mayflower Hotel in Akron, Ohio. Information and reservations may be obtained by addressing "Doctors, Mayflower Hotel, Akron, Ohio."

The Book Corner



New Books Received

School Health Services: Copyright, 1953, by National Education Association, Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the cooperation of contributors and consultants.

Science and Man's Behavior, The Contribution of Phylobiology by the Neurosis of Man: Trigant Burrow, M.D., Ph.D.

Book Review

Respiratory Diseases and Allergy, New Method of Approach: By Josef S. Smul, M.D., Author of "Digestive Diseases and Food Allergy;" Fellow National Gastro-Ent. Assoc.; Member N. Y. Academy of Sciences; formerly Vice President Manhattan Roentgen Ray Society; Assoc. Gastro-Ent. Beth David Hospital; Clin. Asst. Phys. Beth Israel Hospital, New York: Medical Library Company, 1953. Price, $2.75.

Dr. Smul does a beautiful job in attempting to eliminate the confusion regarding the classification and terminology of upper respiratory diseases by recuding some twenty odd acute, chronic, and recurrent respiratory diseases into six forms of diseases. This tendency to incriminate allergy as the cause of respiratory diseases is carried a bit too far, even to the point of listing allergy as the etiology of lung abscess. There is also a short review of the infectious respiratory diseases and of the neoplasms of the respiratory tract.

H. U. WAGGENER, M.D.

Pardon My Sneeze: By Milton Millman, M.D., Fellow, American Academy of Allergists; Member, American Academy of Allergy. Published by Frye and Smith, Limited, San Diego, California.

This small, paper-bound book by a qualified allergist should be a very welcome addition to the ever-growing field of books on allergy for the patient. Written in a bold style with large black print, amusing cartoons, a friendly, easy-going style, it is filled with valuable information.

The book is divided into many small chapters, each a small but complete essay on the subject. Dr. Millman begins with the very first problem of "What Is Allergy?" and goes on to a discussion of the allergic state, the allergic mechanism, the role of nervousness, the technics of diagnosis, the use of allergy tests, and the types of treatment required in allergy disease. A complete picture is drawn of food allergy, hay fever, bronchial asthma, and skin manifestations. One of the most valuable portions of the book is the last forty pages devoted to recipes and menus.

The author properly makes the point that antihistamines are not the treatment for allergies, but should be used along with good allergic management. He carefully notes that routine skin-testing is neither necessary nor important, but stresses the importance of a good history and, even more important, that the patient stick to the one physician rather than chase from one to the other.

While there are a few points in which there

might be minor differences of opinion with some of our "experts" in the field of allergy, the author tries to stick to the middle of the road and give only what is accepted to the patients.

In general the book is earnestly recommended for the perusal of all physicians interested in this field and further recommended to patients who are afflicted with the ever-increasing multitude of allergic diseases and disorders.

Every new patient going to his allergist or to a physicial doing allergy work should be presented with a book of this sort to read in order to give him some idea of what the allergist must go through in order to finally decide on the exact diagnosis and the handling of his case.

ALAN HURST, M.D.

In tuberculosis a realistic acceptance of the illness is a prime essential if medical treatment is to be effective. The patient must not only allow medical procedures to be instituted, but must participate actively in the carrying out of the medical recommendations.—Minna Field, Patients Are People, Columbia University Press, 1953.

The Psychology Of Multiple Sclerosis

Victims of any chronic disease experience psychological stress, but this may be particularly profound in multiple sclerosis sufferers, it is stated in a new booklet for physicians, "Psychological Factors in the Care of Patients With Multiple Sclerosis," written by Dr. Molly R. Harrower, New York psychologist, and Rosalind Herrmann, Boston social worker, and published by the National Multiple Sclerosis Society.

Multiple sclerosis, it is stated in the booklet, is not only chronic, but usually progressive, and unpredictable in its attacks, so that uncertainty plus fear of the future plus worries of the present combine to give multiple sclerotics an unusual share of anxiety. Since no cure for the disease is known, there are unique aspects in the relationship between doctor and patient.

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Colorado Medical Service and Colorado Hospital Service offer sincere congratulations on the outstanding success that you, the doctors and hospitals of Colorado, have made of the Blue Cross and Blue Shield Plans.

Blue Cross and Blue Shield, under your sponsorship and guidance, now serve nearly half of all the residents of Colorado. These two plans have done a great deal to maintain the principles of free enterprise in the Colorado hospital system and to maintain the freedom of the people of Colorado to choose which doctor shall serve them.

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For instance, it has been established that emotional growth occurs not so much in pleasant periods of life but when one is stimulated by difficulty in distressing situations. A doctor, therefore, can assist a patient to discover actual satisfaction in coping with his liabilities; he can help the patient to feel a sense of challenge and even make this challenge to overcome his handicaps a purpose in life. Once a patient can be made to understand that, the greater his emotional maturity and stability, the less his "disability," he will be helped over a large hump.

If the doctor does not maintain a wary eye on his own emotions, he might find his behavior toward his patient typical of the boiling point of frustration, because it is in his nature to want to heal, to cure. If he is not careful, he might transfer disappointment and pessimism to his patient which can do grave emotional harm. Actually, there is enough in the multiple sclerosis situation to warrant hope, and the doctor should approach his patient with the thought uppermost that, though there is no known cure for the disease, many things can be done. Nature itself, the wonders of the patient's own body resistance, can do much to help. About 17 per cent of multiple sclerotics achieve lasting remissions, a state in which they get much better. Also, statistical findings prove that the lives of multiple sclerotics are not much shorter than that of the average individual.

Dr. Harrower states that the optimum solution for the multiple sclerotic is the maintenance to the greatest extent possible of the patient's way of life prior to his illness. In some cases, it is advisable for the individual to find a new means of income suitable to his altered capabilities; in other cases, he might strive to remain in the same career or trade. As regards the problem of employment, Dr. Harrower reminds hopefully: "Confronted with the need to adjust an increasing number of handicapped in a world of war casualties, many communities have developed a greater interest in the handicapped individual. . . . In the rehabilitation effort, we have enlisted the businessman as well as the social agency. . . ."

The new booklet for physicians also states that membership in the National Multiple Sclerosis Society, an organization with thirty-four chapters and about 30,000 members, devoted to research and service in multiple sclerosis, is of great psychological value for victims of the disease. By identifying themselves with this organization, multiple sclerotics achieve a sense of common interest and have the feeling of cooperating with many others in helping to solve their own problems.

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Physicians may obtain the new booklet, "Psychological Factors in the Care of Patients With Multiple Sclerosis," by writing to the National Multiple Sclerosis Society, 270 Park Avenue, New York City. Its companion booklet, for patients, released at an earlier date, "Mental Health and M S," by Dr. Molly R. Harrower, is still obtainable and may be had free of charge by writing to the Society.

Political Health

Under the above title the following Editorial appeared in the January 20, 1954, issue of the Chicago Daily News. It represents the thinking and the policy of one of the nation's great independent dailies concerning a subject that must give the medical profession grave concern in coming months. The editorial is copyrighted by the Chicago Daily News and is reproduced with the permission of that newspaper.

We are a little confused and considerably dismayed by President Eisenhower's proposal to ease the government's toe into the door of the health insurance field.

Passages in his message to Congress seemed to be a bold rejection of plans for socializing medicine. "Freedom, consent and individual responsibility are fundamental to our system," he said. While the Democrats are in no position to do so, they could point out that this sentiment hardly jibes with his recent message on compulsory Social Security.

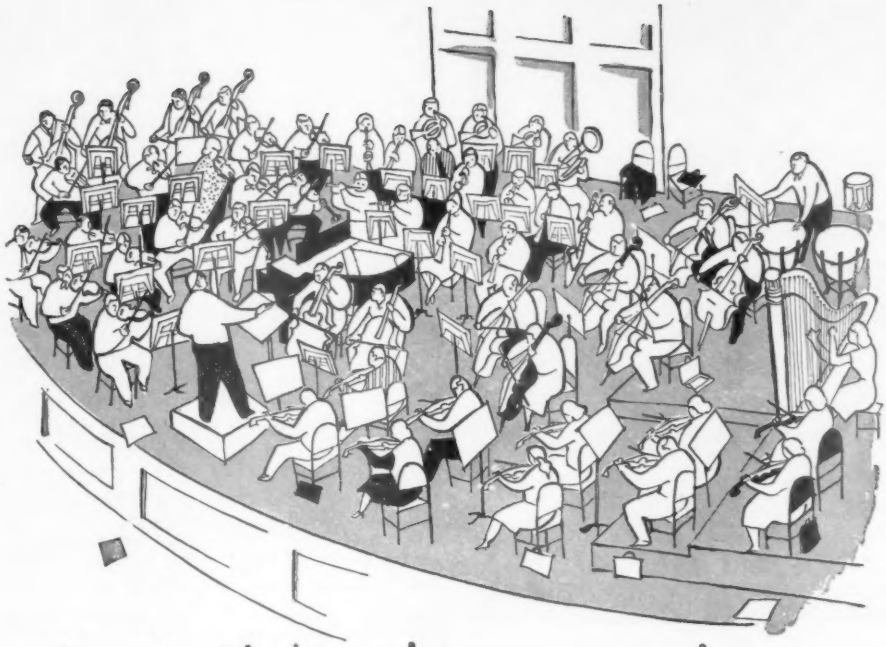
Then, following the tack suggested in his State of the Union message, he recommended the establishment of a government reinsurance corporation. It would "encourage private and nonprofit health insurance organizations to offer broader protection to more families." The $25 million capital required would be recovered from fees charged the private companies, he explained.

This is either a political hoax, a sop to the socialized-medicine claque, or a most naive conception of the reinsurance business.

Private companies in the health insurance field already reinsure each other, just as life insurance companies do, so that one company need retain only a safe proportion, in relation to its assets, of the risk it assumes in insuring any particular group.

The essence of insurance is that an entire group of policyholders will pay premiums sufficient to costs. The premiums vary with the benefits ofmeet all possible claims, plus administrative fered.

Thus it should be quite possible for the 2,000 employees of the PDQ company to buy a group



they could stage their own symphony

. . . all the patients who represent the 44 uses for short-acting

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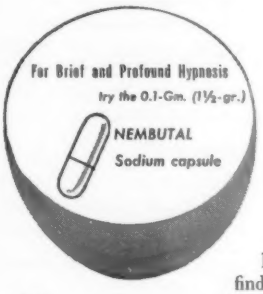

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health insurance policy providing that when any of them got a cold he was entitled to a two-week stay in a gold bed in the Hilton ballroom, with Hollywood starlets for nurses.

The premiums for this fantasy might be prohibitive, but that is the theory of insurance—you get whatever protection terms you pay for.

Now, when the President proposes to put the government into the reinsurance business, one of two things must follow. Either it will be self-supporting from fees, as he suggests, in which case it offers no advantage over the private reinsurance plans already operating. Or else it will not be self-sustaining—which is the more likely—and there you have a government subsidy for health insurance, all ready to be expanded into a full-scale, national, compulsory scheme.

The loss ratio of the private health insurance companies varies less than 10 per cent from year to year, and they pay out something like three quarters of a billion dollars a year in claims. In other words, they know exactly what must be charged to provide the protection they offer.

It is impossible to see what a government reinsurance corporation could introduce into this business—except to sell something below cost—that would add anything not now existing.

A possible preview of the bill that Congress will eventually vote on is that introduced by Rep. Wolverton (R., N. J.). It provides that the government would pay two-thirds of any hospital or medical bill in excess of $1,000 paid in any one year by an insurance policyholder.

It also provides that rates to health plan subscribers must vary in proportion to income. That means that either some must be overcharged, or the government must contribute for the undercharged.

This is backing into socialized medicine, blindfolded. Before starting out so to erect a jerry-built structure of federal "benefits," we might do better to recognize frankly where we are heading, and plan a system of federal subsidies for the ill with as much foresight as possible.

We regret that the President seems to have discarded the rational suggestion for alleviating the burdens of illness advanced last session by Rep. Oliver Bolton (R., Ohio). He offered a measure to make all medical expenses deductible from income for tax purposes. Thereby, the ones who suffered most would obtain the greatest benefit.

This proposal . . . . has the great merit of encouraging preventive health measures, and none of the drawbacks of offering special privilege to any economic group. . . .

SIXTH PAN-PACIFIC SURGICAL CONFERENCE

Doctors are cordially invited to attend the Sixth Congress of the Pan-Pacific Surgical Association to be held in Honolulu, October 7-8,

1954, and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program with over 100 leading surgeons, including sessions in all divisions of surgery and related fields, promises to be of interest to all members of the profession. An extensive social program is being developed for the doctors' families.

The association office has been appointed as travel agent for those attending the Congress and it is important that all hotel and travel reservations be made through the Honolulu headquarters of the Pan-Pacific Surgical Association.

For further information, please write to F. J. Pinkerton, M.D., Director General, Pan-Pacific Surgical Association, Suite Seven, Young Building, Honolulu, Hawaii.

Tuberculosis patients with long-established chronic disease who circulate and act as sources of infection in the community represent a serious situation everywhere. As life is saved or prolonged by treatment, the death rate drops but the number of living patients continues to be high, and in fact, rises in some groups, particularly elderly men.—J. Burns Amberson, M.D., Pub. Health Reports, October, 1953.

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LOCATION WANTED—Experienced general practitioner with surgical training, preferably in community with hospital; association or solo. Contact Box 2a, Rocky Mountain Medical Journal.

OFFICE SPACE for rent. Denver, ideally situated out of down-town district. Adequate parking. Available immediately. For details telephone EAst 5202.

COMPLETING INTERNSHIP July 1st. Married, two children. Interested in general practice. Looking for permanent location in western Montana. For further information write Box 2, Rocky Mountain Medical Journal.

PROFESSIONAL MEN, DOCTORS: 7340 West Colfax, Lakewood business building. 416 sq. ft. of 2nd floor office space available now. Lease. $74.00. WESTERN SECURITIES, AC. 3771 or caretaker, BE. 3-5515.

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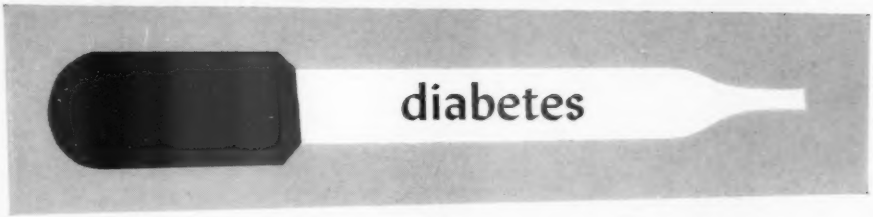

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*Data from nationwide poll: Diabetes in daily practice

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40% had a family history of diabetes.
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1. Blotner, H., and Marble, A.: New England J. Med. *245*:567 (Oct. 11) 1951.
2. Steine, L.: GP *8*:45 (July) 1953.

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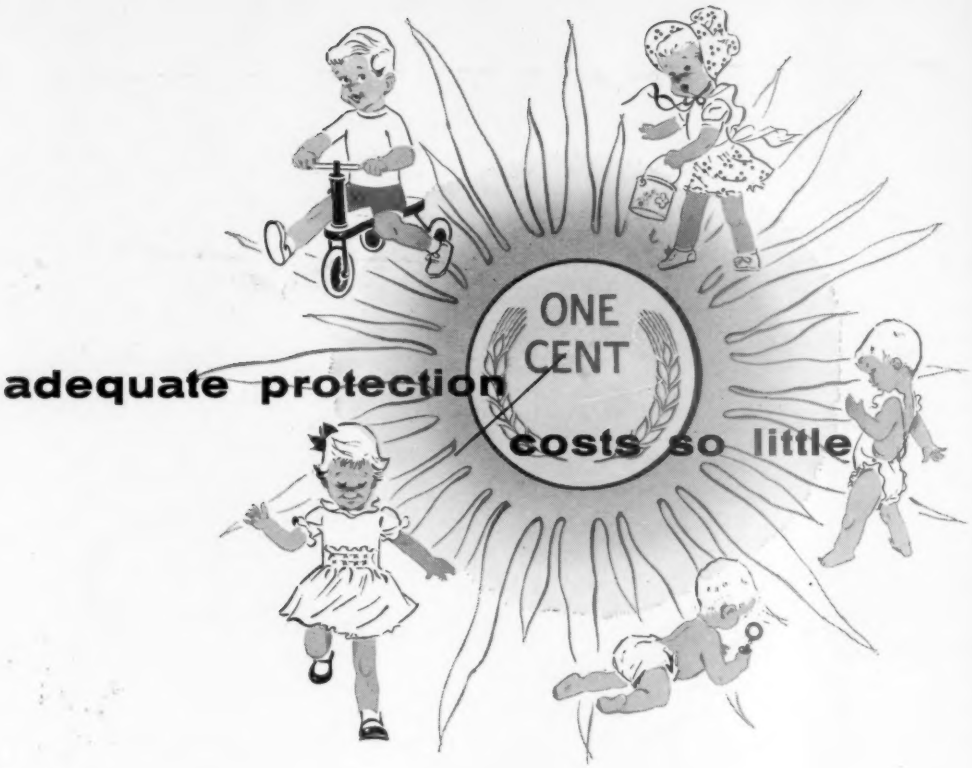

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